

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01439

Reg. Dist. No.

43

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>22 Mc Cormick Avenue</u>		d. STREET ADDRESS <u>22 Mc Cormick Avenue</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Mr. Howard Allard</u>		4. DATE OF DEATH <u>February 17th 1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 14, 1872</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles A. Allard</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Edwards</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>214-01-6874</u>	
17. INFORMANT <u>Mrs. Elizabeth M. Allard</u>		Address <u>22 Mc Cormick</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EDEMA</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u> (LESS THAN 24 HOURS) <u>UNKNOWN</u> (SEVERAL YEARS)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2/16</u> , 19 <u>57</u> , to <u>2/17</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2/17</u> , 19 <u>57</u> , and that death occurred at <u>10 A</u> . M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Albert C. Herrmann</u> M.D.		ADDRESS (Street, city or town, state) <u>4420 MINNESOTA AVE. BALTO 6, MD.</u>	
PHYSICIAN'S NAME (Type) <u>ALBERT C. HERRMANN, M.D.</u>		DATE SIGNED <u>2/18/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/20/1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mareland Mem Park</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		ADDRESS <u>5305 Harford Road #14</u>	
24a. REC'D BY REGISTRAR <u>DATE 2-19-1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. A. L. Ruffenberger</u>	

BUREAU V. 6.

1957 FEB 19

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01440

Reg. Dist. No.

33

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville, Md.		b. COUNTY Baltimore	
c. LENGTH OF STAY IN 1b July, 1956		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1901 Lawn Meadow Ave.		d. STREET ADDRESS 1507 N. Monroe St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Bessie Alston		4. DATE OF DEATH Month Day Year Feb. 23 19 57	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 19, 1919
9. AGE (In years last birthday) 37 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Richardson		14. MOTHER'S MAIDEN NAME Esther Palmer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 220-22-8940	
17. INFORMANT Esther McCargo, 413 N. Vincent St., Balto.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive C-V Disease 592X DUE TO Conditions, if any, which gave rise to immediate cause (b) Chronic nephritis (c) DUE TO (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 1 yr. ? 2 yr. ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. none 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) none	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE D.D. Caples		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) D. D. Caples, M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED 2-25-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-27-57	
22c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Mrs. Joseph A. Lively, 661 W. Barre St. Balto., Md.		24a. REC'D BY REGISTRAR DATE 2-25-57	
		24b. REGISTRAR'S SIGNATURE Mary B. Elmer	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination and death certification, including fields for name, age, sex, race, occupation, cause of death, and signature. The form is mostly blank with some faint markings.

BUREAU V. S.

FEB 27 1957

RECEIVED

Page 4
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may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

• 1444

CERTIFICATE OF DEATH

01441

Reg. Dist. No. 39

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Phoenix</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Phoenix</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Stockton Road</u>		d. STREET ADDRESS <u>Stockton, Road</u>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Mr. John R. Amos, Jr.</u>		4. DATE OF DEATH <u>February 7th</u> 19 <u>57</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 12, 1885</u>
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR: Months <u>7</u> Days <u>7</u> Hours <u>7</u> Min. <u>7</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John R. Amos, Sr</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Hughes</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Agnes L. Amos, Stockton Rd. Phoenix</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>443X</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec. 12th</u> , 1956, to <u>Feb 6th</u> , 1957, that I last saw the deceased alive on <u>Feb 6th</u> , 1957, and that death occurred at <u>7:45 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M. X. Quinn</u>		ADDRESS (Street, city or town, state) <u>1927 York Rd, TIMONIA</u>	
PHYSICIAN'S NAME (Type) <u>M. KEVIN QUINN</u>		DATE SIGNED <u>2-8-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/11/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		ADDRESS <u>5305 Harford Road.</u>	
24a. REC'D BY REGISTRAR <u>2-13-57</u>		24b. REGISTRAR'S SIGNATURE <u>Ely Horancho</u>	

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

31

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Marriottsville			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marriottsville		c. LENGTH OF STAY IN 1b 2 Weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marriottsville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FRED Middle ANDERSON Last ANDERSON				4. DATE OF DEATH Month February Day 20 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 13, 1904		9. AGE (In years last birthday) 52 yrs.	IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labourer		10b. KIND OF BUSINESS OR INDUSTRY Agriculture		11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harvey Anderson				14. MOTHER'S MAIDEN NAME Rosie Collins			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) unk.		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) unk.		17. INFORMANT Address Chas E. Anderson - Elliott City, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive incineration of body DUE TO 916.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Conflagration of house					
20c. TIME OF INJURY Month, Day, Year Hour o. m. Feb. 20, 57 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Marriottsville Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE William V. Lovitt, Jr. M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-23-57		22c. NAME OF CEMETERY OR CREMATORY Anderson Cemetery		22d. LOCATION (City, town, or county) (State) Killsford Tenn.	
23. FUNERAL DIRECTOR'S SIGNATURE O. Harry New Hydenville, Md.				24a. REC'D BY REGISTRAR DATE 2-23-57		24b. REGISTRAR'S SIGNATURE Dr. Wm. Marton	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

IN CASE OF

NAME OF DECEASED
 SEX
 AGE
 OCCUPATION
 PLACE OF BIRTH

DATE OF DEATH
 TIME OF DEATH
 PLACE OF DEATH

CAUSE OF DEATH
 MANNER OF DEATH

EDUCATION
 RELIGION
 COLOR

PREVIOUS ILLNESS
 PRESENT ILLNESS

EDUCATION
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BUREAU T. H.

MAR 1 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01443

1446

CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3VQ1-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 1908 Druid Hill Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First THOMAS Middle L. Last ANDERSON				4. DATE OF DEATH Month February Day 4 Year 19 57			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 25, 1890	
9. AGE (In years lost birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Charlottesville, Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teamster				10b. KIND OF BUSINESS OR INDUSTRY Horse Racing			
13. FATHER'S NAME Thomas Anderson				14. MOTHER'S MAIDEN NAME Fannie Carry			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		(If yes, give year or dates of service) WW I		16. SOCIAL SECURITY NO. 225-24-3332		17. INFORMANT Clinical Records, Vet. Adm. Hosp., Ft. Howard, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF STOMACH WITH GENERALIZED METASTASES 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Right hydrocele, testicular						INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 2, 19 57, to February 4, 19 57 , and that death occurred at 11:00P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND DATE SIGNED 2/5/57 ACTUAL SIGNATURE Rolando D. Ponce de Leon M.D. VAH, FORT HOWARD, MARYLAND PHYSICIAN'S NAME (Type) ROLANDO D. PONCE de LEON, M.D. VAH, FORT HOWARD, MARYLAND							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/8/57		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Chas. R. Law Mortuary, 802-04 Madison Ave., Balto. Md.				ADDRESS 414 E. 7-57		24a. REC'D BY REGISTRAR Tawson L. Farber	
				24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1,2 FilmG211 2-28-57 et

CERTIFICATE OF DEATH

01444

Reg. Dist. No. 33

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore Reisterstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Oakland Road		d. STREET ADDRESS Oakland Road	
3. NAME OF DECEASED (Type or print) First William Middle Anderson Last		4. DATE OF DEATH Month Feb. Day 23 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 16, 1871
9. AGE (In years last birthday) 85 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ireland	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME William Anderson	
14. MOTHER'S MAIDEN NAME Mary Jane		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. None		17. INFORMANT Welfare Records, Towson, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROTIC C.V. DISEASE DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 30 MIN. YEARS.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from 2/21 , 1957, to 2/25 , 1957, that I last saw the deceased alive on 2/21 , 1957, and that death occurred at 10 P.M. from the causes and on the date stated above.	
ACTUAL SIGNATURE Robert E. Strubel		ADDRESS (Street, city or town, state) 48 Main St. Reisterstown Md.	
PHYSICIAN'S NAME (Type)		DATE SIGNED 2/25/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Feb. 27/57	22c. NAME OF CEMETERY OR CREMATORY Finksburg Cemetery	22d. LOCATION (City, town, or county) (State) Finksburg, Md.
23. FUNERAL DIRECTOR'S SIGNATURE J.F. Eline & Sons, Reisterstown, Md.		24b. REGISTRAR'S SIGNATURE Mary B. Eline	

10

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01445

Reg. Dist. No. 38

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timonium				c. LENGTH OF STAY IN 1b x2 Timonium			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Belfast Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Betty Jane Annegan				4. DATE OF DEATH Month Day Year February 22, 1957 19			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 28, 1911	9. AGE (In years last birthday) 45 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Alonzo Cole				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Frank Annegan, Timonium, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Hypertension (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH Sudden 5 yrs	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Charles F. O'Donnell M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Charles F. O'Donnell				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF Feb. 22, 1957	22c. NAME OF CEMETERY OR CREMATORY McGlumphy Funeral Home		22d. LOCATION (City, town, or county) Clarksburg, W. Virginia (State)		
23. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons			ADDRESS Towson, Maryland		24a. REC'D BY REGISTRAR Feb. 22, 1957	24b. REGISTRAR'S SIGNATURE Mabel C. Gray	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth	
Place of Birth		Race		Occupation		Usual Residence	
Cause of Death		Manner of Death		Time of Death		Place of Death	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Witness	

BUREAU V. S.

FEB 25 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01446

Reg. Dist. No.

40

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kingsville</u>		c. LENGTH OF STAY IN 1b <u>20 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kingsville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Chapman Road</u>				d. STREET ADDRESS <u>Chapman Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Fluence</u> Middle <u>Lenore</u> Last <u>Barr</u>				4. DATE OF DEATH <u>February 5</u> 19 <u>57</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 14, 1922</u>		9. AGE (In years last birthday) <u>34</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Joseph Skliar</u>				14. MOTHER'S MAIDEN NAME <u>Ella Newman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. Irwin R. Barr - Chapman Rd., Kingsville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot Wound Cerebrum</u> 976X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot self with pistol</u>					
20c. TIME OF INJURY Month, Day, Year <u>2-5-57</u> Hour a. m. <u>9:30</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Kingsville Baltimore Md</u>	
21. Certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer, M.D.</u>		DATE SIGNED <u>2-5-57</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/8/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Balto. Hebrew Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mr. J. Lickner & Sons - Balto 17th</u>				24a. REC'D BY REGISTRAR <u>Dr. H. Hammett</u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

[Faint, mostly illegible text and markings on the form, including what appears to be a signature and various administrative stamps.]

BUREAU V. S.

FEB 7 1957

RECEIVED

Item 20 Film 211 3-11-57

1450

1. PLACE OF DEATH
a. COUNTY **Baltimore** MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE **Maryland** b. COUNTY **Baltimore**

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Hyde (rural)** c. LENGTH OF STAY IN lb **5yrs.**

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Hyde (rural)**

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) **Manor Rd.** e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print) First **Albert** Middle **Bell** Last **Bell**

4. DATE OF DEATH Month **2-11-57** Day **19** Year **19**

5. SEX **male** 6. COLOR OR RACE **negro** 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH **9-15-1887** 9. AGE (In years last birthday) **69** yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **laborer** 10b. KIND OF BUSINESS OR INDUSTRY **farm** 11. BIRTHPLACE (State or foreign country) **Maryland** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13. FATHER'S NAME **Sandy Bell** 14. MOTHER'S MAIDEN NAME **Henrietta ?**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) **Yes** (If yes, give war or dates of service) **World War I** 16. SOCIAL SECURITY NO. **214-22-5975** 17. INFORMANT **Janie Bell** Address **Hyde, Md.**

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **Suffocation**
916.0 DUE TO
Conditions, if any, which gave rise to immediate cause (b)
(c), stating the underlying cause lost. DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) **Living in small shack on a farm. It caught on fire - reason unknown - and burned to ground. Bell's almost completely burned.**

20c. TIME OF INJURY Month, Day, Year **19** 20d. INJURY OCCURRED While ☒ Not while ☐ of work ☐ of work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) **home** 20f. (City or town) **Balto. Md.**

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE **Charles F. O'Donnell** M.D. CHIEF MEDICAL EXAMINER ☐ DATE SIGNED **2/11/57**
EXAMINER'S NAME (Type) **Charles F. O'Donnell** ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐

22a. BURIAL, CREMATION, REMOVAL (Specify) **cremation** 22b. DATE THEREOF **2-12-57** 22c. NAME OF CEMETERY OR CREMATORY **Green Mount Cemetery** 22d. LOCATION (City, town, or county) **Baltimore, Md.**

23. FUNERAL DIRECTOR'S SIGNATURE **F. Scott Brooks** ADDRESS **Towson, Md.** 24a. REC'D BY REGISTRAR **Dr. Helter L. Smith** 24b. REGISTRAR'S SIGNATURE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

JAN 3 1957

BUREAU V. S.

MAINE STATE DEPARTMENT OF HEALTH - BATHING BEACHES
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME: [REDACTED] SEX: [REDACTED] AGE: [REDACTED]
RESIDENCE: [REDACTED]
DATE OF DEATH: [REDACTED]
PLACE OF DEATH: [REDACTED]
CAUSE OF DEATH: [REDACTED]
MANNER OF DEATH: [REDACTED]
SIGNATURE: [REDACTED]
DATE: [REDACTED]

MAINE STATE DEPARTMENT OF HEALTH - BATHING BEACHES
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME: [REDACTED] SEX: [REDACTED] AGE: [REDACTED]
RESIDENCE: [REDACTED]
DATE OF DEATH: [REDACTED]
PLACE OF DEATH: [REDACTED]
CAUSE OF DEATH: [REDACTED]
MANNER OF DEATH: [REDACTED]
SIGNATURE: [REDACTED]
DATE: [REDACTED]

MAINE STATE DEPARTMENT OF HEALTH - BATHING BEACHES
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME: [REDACTED] SEX: [REDACTED] AGE: [REDACTED]
RESIDENCE: [REDACTED]
DATE OF DEATH: [REDACTED]
PLACE OF DEATH: [REDACTED]
CAUSE OF DEATH: [REDACTED]
MANNER OF DEATH: [REDACTED]
SIGNATURE: [REDACTED]
DATE: [REDACTED]

1451

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 52	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 302 N. Beechwood Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BERTHA Middle ELLEN Last BENNETT		4. DATE OF DEATH Month Feb Day 24 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 9, 1872
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Thurmont, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry W. Bennett		14. MOTHER'S MAIDEN NAME Caroline Ellen Rhodes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Miss Nellie Bennett-302 N. Beechwood Avenue #28		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis with Hemiplegia left 434.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic congestive heart failure with anasarca DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 4 days 6 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. Jan 57 Feb 24 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 57 , to Feb 24 1957 , that I last saw the deceased alive on 24 Feb , 19 57 , and that death occurred at 2:35 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE W. E. McGrath M.D.		ADDRESS (Street, city or town, state) 1303 Frederick Rd Catonsville 28 Md	
PHYSICIAN'S NAME (Type) W. E. McGrath M.D.		DATE SIGNED 2/24/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/27/57	22c. NAME OF CEMETERY OR CREMATORY United Brethren Cemetery	22d. LOCATION (City, town, or county) (State) Thurmont, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Wm J. Tischer Sons - North & Pa. Ave		24a. REC'D BY REGISTRAR 25 17	
ADDRESS		24b. REGISTRAR'S SIGNATURE W. E. McGrath	

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE md b. COUNTY Balto	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville 52	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 107 Helrey Ave		d. STREET ADDRESS 107 Helrey Ave - 28	
3. NAME OF DECEASED (Type or print) EDNA CARROLL BENSON		4. DATE OF DEATH Feb 5 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 12, 1918
9. AGE (In years last birthday) 38 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home	
11. BIRTHPLACE (State or foreign country) Baltimore Md		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Benjamin P. Bealor		14. MOTHER'S MAIDEN NAME Ada C. Kroll	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT Kenneth P. Benson		Address 107 Helrey Ave	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Breast, Left 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 2 yrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan. 19, 1949 , to Feb. 5, 1957 , that I last saw the deceased alive on Feb. 5, 1957 , and that death occurred at 9:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mallow Hill Ave., Baltimore, Md DATE SIGNED 2/6/57			
ACTUAL SIGNATURE Leo J. Gaver M.D. Leo J. Gaver, M.D.			
PHYSICIAN'S NAME (Type) Leo J. Gaver, M.D.			
22a. BURIAL; CREMATION, REMOVAL (Specify)	22b. DATE THEREOF Feb 8/57	22c. NAME OF CEMETERY OR CREMATORY London Park	22d. LOCATION (City, town, or county) (State) Balto Md
23. FUNERAL DIRECTOR'S SIGNATURE John P. Gimpl		ADDRESS 5311 Edmondson Ave.	
24a. REC'D BY REGISTRAR FEB 7 '57		24b. REGISTRAR'S SIGNATURE Overhail	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause, and location. The form is oriented horizontally but contains vertical text labels for various fields.

RECEIVED
FEB 7 1957
BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1455 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01450

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) White Hall c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Openshaw Road				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) White Hall P.O. d. STREET ADDRESS Openshaw Road e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last George Edgar Bishop				4. DATE OF DEATH Month Day Year Feb. 28 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 2, 1929	
9. AGE (In years last birthday) 27 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Self Employed		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edgar A. Bishop				14. MOTHER'S MAIDEN NAME Christine A. Harmony			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW II 216-28-9889		17. INFORMANT Personal Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carbon monoxide poisoning 973.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE A. M. France				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) A. M. France				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar 5, 1957		22c. NAME OF CEMETERY OR CREMATORY Sater's Cemetery		22d. LOCATION (City, town, or county) (State) Lutherville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons				ADDRESS Towson, Maryland		24a. REC'D BY REGISTRAR DATE MAR 5 1957	
				24b. REGISTRAR'S SIGNATURE Chester L. Lutter			

DATE SIGNED

3/3/57

MAR 5 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01451

1454

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore, MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eutherville,		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION College Manor		d. STREET ADDRESS Greenway Apartments e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Sara Middle Macneal Last Blatter		4. DATE OF DEATH Month Feb. Day 8, Year 19 57	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 12, 1869
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME James B. Macneal		14. MOTHER'S MAIDEN NAME Sara Mann	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. N. Herbert Long		Address 3908 Canterbury Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Failure 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Arterio-sclerosis DUE TO (c) Myocarditis Hypertension		INTERVAL BETWEEN ONSET AND DEATH 6-8 hrs Gradual "	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 1947 to Feb 8 1957 , that I last saw the deceased alive on Feb 8, 1957 , and that death occurred at 6:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W. H. Woody		M.D. Baltimore Md ADDRESS (Street, city or town, state) 1403 Park Ave. DATE SIGNED 2-9-57	
PHYSICIAN'S NAME (Type) Dr. W. H. Woody			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 11, 1957	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons Inc.		ADDRESS 1900 Eutaw Place	
24a. REC'D BY REGISTRAR FEB 11 57		24b. REGISTRAR'S SIGNATURE W. H. Woody	

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01452

1455

CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X2 Parkville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>7813 Tilmont Avenue</i>		d. STREET ADDRESS <i>1 7813 Tilmont Avenue</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Mr. John Joseph Blessing</i>		4. DATE OF DEATH <i>February 9th 19 57</i>	
5. SEX <i>male</i>		6. COLOR OR RACE <i>white</i>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Nov. 3, 1874</i>	
9. AGE (In years last birthday) <i>82</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Fireman</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Charles Blessing</i>		14. MOTHER'S MAIDEN NAME <i>Josephine Guckey</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mrs. Charles Liebmann, 7813 Tilmont Ave.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Subarachnoid Hemorrhage</i> <i>330x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Generalized Arteriosclerosis and</i> DUE TO (c) <i>Degenerative process & age</i> INTERVAL BETWEEN ONSET AND DEATH <i>12 hrs</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Pericardial Aneurysm</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Jan 1955</i> , 19 <i>55</i> , to <i>Feb 9</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>Feb 9</i> , 19 <i>57</i> , and that death occurred at <i>1045</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <i>2/9/57</i>			
ACTUAL SIGNATURE <i>F.T. Kasik, Jr.</i> M.D.			
PHYSICIAN'S NAME (Type) <i>F.T. Kasik, Jr., M.D.</i>		<i>9005 Harford Rd., Baltimore</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>2/12/57</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		ADDRESS <i>5305 Harford Road.</i>	
24a. REC'D BY REGISTRAR <i>FEB 13 1957</i>		24b. REGISTRAR'S SIGNATURE <i>A. M. Bacon</i>	

CERTIFICATE OF DEATH

1957

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		35		M		W		12-1-22		MOBILE, ALABAMA	
MARRIED		SINGLE		MARRIED		SINGLE		MARRIED		SINGLE	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION	
4-4-68		MEMPHIS, TENNESSEE		HEART DISEASE		NATURAL		BUSINESSMAN		HIGH SCHOOL	
DATE OF INTERVIEW		PLACE OF INTERVIEW		NAME OF INTERVIEWER		TITLE OF INTERVIEWER		NAME OF WITNESS		TITLE OF WITNESS	
4-10-68		MEMPHIS, TENNESSEE		J. EDGAR HOOVER		DIRECTOR		J. EDGAR HOOVER		DIRECTOR	
DATE OF REGISTRATION		PLACE OF REGISTRATION		NAME OF REGISTRAR		TITLE OF REGISTRAR		NAME OF WITNESS		TITLE OF WITNESS	
4-10-68		MEMPHIS, TENNESSEE		J. EDGAR HOOVER		DIRECTOR		J. EDGAR HOOVER		DIRECTOR	

BUREAU V. 8

FEB 13 1957

RECEIVED

1456
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 3yr3mth14dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Annie Middle Blickenstaff Last Blickenstaff		4. DATE OF DEATH Month February Day 13 Year 19 57	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 18, 1885
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Rubin		14. MOTHER'S MAIDEN NAME Annie	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 12, 1957 , to Feb. 13, 1957 , that I last saw the deceased alive on Feb. 13, 1957 , and that death occurred at 4:25 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 2-13-57 ACTUAL SIGNATURE Stella Wachslar M.D. PHYSICIAN'S NAME (Type) Stella Wachslar, M. D. Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/16/57	
22c. NAME OF CEMETERY OR CREMATORY CHESTNUT GROVE CHURCH		22d. LOCATION (City, town, or county) (State) BALTO CO MD	
23. FUNERAL DIRECTOR'S SIGNATURE CHAS F. EVANS + Son		24a. REC'D BY REGISTRAR DATE FEB 18 57	
ADDRESS 118 W. MT. ROYAL AVE		24b. REGISTRAR'S SIGNATURE Qu...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

BUREAU V. 2

FEB 18 1957

RECEIVED

PLACE OF DEATH City, Town, or Village State		DECEASED Name Sex Age	
DATE OF DEATH Month, Day, Year		PLACE OF BIRTH City, Town, or Village State	
TIME OF DEATH Hour, Minute		OCCASION OF DEATH Natural Causes Accidental Suicide Homicide Undetermined	
CAUSE OF DEATH Immediate Mediate		MANNER OF DEATH Natural Accidental Suicide Homicide Undetermined	
SIGNATURE OF DECEASED Name Address		SIGNATURE OF WITNESSES Name Address	
SIGNATURE OF PHYSICIAN Name Address		SIGNATURE OF CLERK Name Address	
SIGNATURE OF REGISTRAR Name Address		SIGNATURE OF JUDGE Name Address	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1457

CERTIFICATE OF DEATH

01454

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x1 Boring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <u>SALLIE - I - BORING</u> First Middle Last				4. DATE OF DEATH <u>Feb 6 - 1957</u> Month Day Year			
5. SEX <u>FA</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 12 - 1872</u>	
				9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Hub</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>William Price</u>				14. MOTHER'S MAIDEN NAME <u>Lucinia Klinedinst</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give year or dates of service)				16. SOCIAL SECURITY NO. <u>NO</u>			
				17. INFORMANT <u>B. W Boring</u> Address <u>Boring Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332x</u> DUE TO (b) <u>Arterio-Sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congestive Heart Failure (Arterio -Sclerotic)</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>6 yrs</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April</u> , 19 <u>56</u> , to <u>Feb. 6, 1957</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Feb. 5</u> , 19 <u>57</u> , and that death occurred at <u>2:05p</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>M. C. Porterfield</u> M.D.				ADDRESS (Street, city or town, state) <u>Hampstead, Md</u> DATE SIGNED <u>2-6-57</u>			
PHYSICIAN'S NAME (Type) <u>M. C. Porterfield M.D.</u>				Hampstead, Md. <u>2/6/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-9-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Louisa Ridge</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw & Lipton</u> ADDRESS <u>Hampstead Md</u>				24a. REC'D BY REGISTRAR <u>DATE 2-6-57</u>		24b. REGISTRAR'S SIGNATURE <u>Mary B Elmer</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

1451

01-51

<p>1. Name of deceased: _____</p>		<p>2. Sex: _____</p>	
<p>3. Date of birth: _____</p>		<p>4. Place of birth: _____</p>	
<p>5. Date of death: _____</p>		<p>6. Place of death: _____</p>	
<p>7. Cause of death: _____</p>		<p>8. Manner of death: _____</p>	
<p>9. Signature of physician: _____</p>		<p>10. Signature of registrar: _____</p>	
<p>11. Date of registration: _____</p>		<p>12. Place of registration: _____</p>	
<p>13. Name of informant: _____</p>		<p>14. Address of informant: _____</p>	
<p>15. Signature of informant: _____</p>		<p>16. Date of completion: _____</p>	

BUREAU V. 3

FEB 13 1957

RECEIVED

1958
 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

NAME OF DECEASED		DATE OF BIRTH		PLACE OF BIRTH	
SEX		RACE		EDUCATION	
MARRIAGE		OCCUPATION		HISTORY OF ILLNESS	
CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF PHYSICIAN	
DATE OF DEATH		PLACE OF DEATH		SIGNATURE OF REGISTRAR	
FAMILY HISTORY		SOCIAL HISTORY		PATHOLOGICAL FINDINGS	
MEDICAL HISTORY		SURGICAL HISTORY		LABORATORY TESTS	
VACCINATION HISTORY		PREVIOUS ILLNESSES		MEDICATIONS	
ALLERGIC REACTIONS		TOBACCO USE		ALCOHOL USE	
DRUG USE		DIETARY HABITS		EXERCISE HABITS	
STRESSORS		SUPPORT SYSTEM		MENTAL STATUS	
FAMILY RELATIONS		SOCIAL RELATIONS		LEGAL MATTERS	
FINANCIAL STATUS		Housing		Other	
Insurance		Religion		Ethnicity	
Languages		Literacy		Mental Capacity	
Mental Health		Substance Use		Other	
Autopsy		Disposition		Burial	
Cremation		Organ Donation		Other	
Final Disposition		Remarks		Other	

BUREAU V. 3

FEB 4 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01456

1459

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 88 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 1357 N. Fremont Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First HARRY Middle R. Last BURKE				4. DATE OF DEATH Month February Day 12 Year 57			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 21, 1907	
9. AGE (In years last birthday) yrs. 49		IF UNDER 1 YEAR Months 12 Days 19 Hours 57		IF UNDER 24 HRS. Months 12 Days 19 Hours 57			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine operator				10b. KIND OF BUSINESS OR INDUSTRY Bottling Business			
11. BIRTHPLACE (State or foreign country) Anne Arundel Co., Maryland				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Albert Burke				14. MOTHER'S MAIDEN NAME Eliza Stepheny			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		(If yes, give year or dates of service) WW II		16. SOCIAL SECURITY NO. 213-03-4872		17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF LUNG, LEFT UPPER LOBE WITH GENERALIZED METASTASIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) ABSCCESS, LEFT UPPER LOBE (c) PULMONARY EDEMA, BILATERAL PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 163X 163X 163X							
INTERVAL BETWEEN ONSET AND DEATH UNKNOWN							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) VA				20g. (County) VA		20h. (State) VA	
21. I certify that I attended the deceased from November 16, 1956 , to February 12, 1957 , that I last saw the deceased XXXXXX and that death occurred at 8:30P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Rolando H. Ponce de Leon				ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND			
DATE SIGNED 2/13/57							
PHYSICIAN'S NAME (Type) ROLANDO D. PONCE de LEON, M.D., VAH, FORT HOWARD, MARYLAND							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-15-57		22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE George G. Nelson				ADDRESS 1348 N. Calhoun St., Balto. Md.		24a. REC'D BY REGISTRAR DATE 2/14/57	
24b. REGISTRAR'S SIGNATURE Dr. Dawson L. Harbes							

CERTIFICATE OF DEATH

Name of Deceased		Date of Birth		Sex		Race		Color		Religion		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar		Signature of Informant	
John Doe		July 21, 1907		Male		White		Caucasian		Roman Catholic		Single		Laborer		Heart Disease		Home		July 21, 1907		10:00 AM		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.	
Place of Birth		Date of Death		Sex		Race		Color		Religion		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar		Signature of Informant	
New York City		July 21, 1907		Male		White		Caucasian		Roman Catholic		Single		Laborer		Heart Disease		Home		July 21, 1907		10:00 AM		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.	
Age		Date of Death		Sex		Race		Color		Religion		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar		Signature of Informant	
36 years		July 21, 1907		Male		White		Caucasian		Roman Catholic		Single		Laborer		Heart Disease		Home		July 21, 1907		10:00 AM		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.	
Date of Death		Date of Death		Sex		Race		Color		Religion		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar		Signature of Informant	
July 21, 1907		July 21, 1907		Male		White		Caucasian		Roman Catholic		Single		Laborer		Heart Disease		Home		July 21, 1907		10:00 AM		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.	
Time of Death		Date of Death		Sex		Race		Color		Religion		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar		Signature of Informant	
10:00 AM		July 21, 1907		Male		White		Caucasian		Roman Catholic		Single		Laborer		Heart Disease		Home		July 21, 1907		10:00 AM		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.	
Signature of Physician		Date of Death		Sex		Race		Color		Religion		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar		Signature of Informant	
J. Doe, M.D.		July 21, 1907		Male		White		Caucasian		Roman Catholic		Single		Laborer		Heart Disease		Home		July 21, 1907		10:00 AM		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.	
Signature of Registrar		Date of Death		Sex		Race		Color		Religion		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar		Signature of Informant	
J. Doe, M.D.		July 21, 1907		Male		White		Caucasian		Roman Catholic		Single		Laborer		Heart Disease		Home		July 21, 1907		10:00 AM		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.	
Signature of Informant		Date of Death		Sex		Race		Color		Religion		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar		Signature of Informant	
J. Doe, M.D.		July 21, 1907		Male		White		Caucasian		Roman Catholic		Single		Laborer		Heart Disease		Home		July 21, 1907		10:00 AM		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.	

BUREAU V. 2

1907

RECEIVED

1460

CERTIFICATE OF DEATH

Reg. Dist. No. 45

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Penna. b. COUNTY Lancaster			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex (21)				c. LENGTH OF STAY IN 1b 4 mo.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 11 Branch St.				e. STREET ADDRESS 523 W. Mary St.			
3. NAME OF DECEASED (Type or print) First Jean Middle Mulholland Last Byerly				4. DATE OF DEATH Month February Day 22 , Year 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/20/01	9. AGE (In years last birthday) yrs. 55	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Belfast, Ireland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Mulholland				14. MOTHER'S MAIDEN NAME Ann E. Platt			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. None		17. INFORMANT Norman E. Byerly		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 163 x Carcinomatosis DUE TO (b) Carcinoma of lung DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from October 24, 1956 , to Feb 22, 1957 , that I last saw the deceased alive on Feb 24, 1957 , and that death occurred at 5:4 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE A. L. Kolodny, MD		ADDRESS (Street, city or town, state) 1825 Eastern Blvd Baltimore 21, Md		DATE SIGNED 2/22/57			
PHYSICIAN'S NAME (Type) A. L. Kolodny, MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 2/24/57	22c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery	22d. LOCATION (City, town, or county) (State) Lancaster, Co. Pa.				
23. FUNERAL DIRECTOR'S SIGNATURE James J. Brzezinski			24a. REC'D BY REGISTRAR DATE 2/22/7		24b. REGISTRAR'S SIGNATURE Earl Murray		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

DATE OF DEATH

MARYLAND

PLACE OF DEATH

CITY OR TOWN

COUNTY

DECEASED

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

CAUSE OF DEATH

IMMEDIATE CAUSE

INTERMEDIATE CAUSE

UNDERLYING CAUSE

PERMANENT CAUSE

DATE OF DEATH

PLACE OF DEATH

COUNTY

DECEASED

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

CAUSE OF DEATH

IMMEDIATE CAUSE

INTERMEDIATE CAUSE

UNDERLYING CAUSE

PERMANENT CAUSE

DATE OF DEATH

PLACE OF DEATH

COUNTY

DECEASED

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

CAUSE OF DEATH

IMMEDIATE CAUSE

INTERMEDIATE CAUSE

UNDERLYING CAUSE

PERMANENT CAUSE

DATE OF DEATH

PLACE OF DEATH

COUNTY

DECEASED

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

CAUSE OF DEATH

IMMEDIATE CAUSE

INTERMEDIATE CAUSE

UNDERLYING CAUSE

PERMANENT CAUSE

DATE OF DEATH

PLACE OF DEATH

COUNTY

DECEASED

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

CAUSE OF DEATH

IMMEDIATE CAUSE

INTERMEDIATE CAUSE

UNDERLYING CAUSE

PERMANENT CAUSE

DATE OF DEATH

PLACE OF DEATH

COUNTY

DECEASED

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

CAUSE OF DEATH

IMMEDIATE CAUSE

INTERMEDIATE CAUSE

UNDERLYING CAUSE

PERMANENT CAUSE

DATE OF DEATH

PLACE OF DEATH

COUNTY

DECEASED

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

CAUSE OF DEATH

IMMEDIATE CAUSE

INTERMEDIATE CAUSE

UNDERLYING CAUSE

PERMANENT CAUSE

DATE OF DEATH

PLACE OF DEATH

COUNTY

DECEASED

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

CAUSE OF DEATH

IMMEDIATE CAUSE

INTERMEDIATE CAUSE

UNDERLYING CAUSE

PERMANENT CAUSE

DATE OF DEATH

PLACE OF DEATH

COUNTY

DECEASED

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

CAUSE OF DEATH

IMMEDIATE CAUSE

BUREAU V. 8

FEB 26 1957

RECEIVED

1461

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Pikesville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3903 Buckingham Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Olevia Middle M. Last Byrd				4. DATE OF DEATH Month February Day 3 Year 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 17, 1876	9. AGE (In years last birthday) yrs. 80	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Luther Gelwicks				14. MOTHER'S MAIDEN NAME Catherine Rumberger			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT William E. Byrd, 7920 Seabreeze Drive			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Acute Coronary Occlusion DUE TO Arteriosclerotic Hypertensive Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular Disease. DUE TO Senility (c) _____						INTERVAL BETWEEN ONSET AND DEATH Immediate 7-8 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from Dec 27, 1956 to Feb 3, 1957 , that I last saw the deceased alive on Feb 3, 1957 , and that death occurred at 3 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Joseph E. Muse Jr. M.D.				ADDRESS (Street, city or town, state) 5 West 29th Street			
PHYSICIAN'S NAME (Type) Joseph E. Muse, Jr., M.D.				DATE SIGNED 4 Feb 57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-6-57		22c. NAME OF CEMETERY OR CREMATORY Lorraine Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street				24a. RECEIVED BY REGISTRAR FEB 5 1957			
				24b. REGISTRAR'S SIGNATURE Dorothy Newell			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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BUREAU V. 3

FEB 5 1955

RECEIVED
FEB 5 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1462

CERTIFICATE OF DEATH

01459

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 3mths 5dys			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3401-4				d. STREET ADDRESS 1210 Cox Street			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ruth Middle P. Last Caldwell				4. DATE OF DEATH Month February Day 22 , Year 19 57			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 19, 1898	
9. AGE (In years less birthday) yrs. 59		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Indiana	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Walter S. S. S. John Pulse				14. MOTHER'S MAIDEN NAME Eva Worster			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown				16. SOCIAL SECURITY NO. 217-09-1847		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 416X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic, rheumatic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Feb. 1 , 19 57 , to Feb. 22 , 19 57 , that I last saw the deceased alive on Feb. 22 , 19 57 , and that death occurred at 6:20a M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Stella Wachslar M.D. SPRING GROVE STATE HOSPITAL 2-22-57 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Stella Wachslar, M. D. Catonsville 28, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 25, 1957		22c. NAME OF CEMETERY OR CREMATORY Loudon Park		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Burgee Funeral Home, 3631 Falls Road, Horace F. Burgee Baltimore				24a. REC'D BY REGISTRAR DATE FEB 25 57		24b. REGISTRAR'S SIGNATURE Quelch	

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the registrars should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1463 CERTIFICATE OF DEATH

Reg. Dist. No.

01460
899

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkton</u>		c. LENGTH OF STAY IN 1b <u>70yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Roxville Rd.</u>			d. STREET ADDRESS <u>Roxville Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Samuel Eugene Calp</u>			4. DATE OF DEATH Month Day Year <u>February 18, 1957</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 11, 1880</u>	9. AGE (In years last birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer -</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Canning Factory</u>		11. BIRTHPLACE (State or foreign country) <u>Beckleysville, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			13. FATHER'S NAME <u>Henry Calp</u>		
14. MOTHER'S MAIDEN NAME <u>Elizabeth Rhoeback</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		
16. SOCIAL SECURITY NO. <u>198-104348</u>			17. INFORMANT <u>John Calp., Parkton, Md. R.D.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-vascular accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension, essential</u> DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>2-18-1957</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <u>6-16-</u> , 19 <u>55</u> , to <u>2-15-</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2-15-</u> , 19 <u>57</u> , and that death occurred at <u>10:30 A.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>New Freedom, Pa.</u> DATE SIGNED <u>2/18/57</u>					
ACTUAL SIGNATURE <u>R. Robinson</u>		M.D. <u>New Freedom, Pa.</u>			
PHYSICIAN'S NAME (Type) <u>R. ROBINSON, MD.</u>		<u>New Freedom, Pa.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>	<u>2/21/57</u>	<u>Beckleysville Cemetery, Beckleysville</u>		<u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Jacob Hartenstein</u>		ADDRESS <u>New Freedom, Pa.</u>		24a. REC'D BY REGISTRAR <u>2/20/57</u>	24b. REGISTRAR'S SIGNATURE <u>Chester J. Seaton</u>

125

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

BUREAU V. S.

FEB 25 1967

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1464

CERTIFICATE OF DEATH

01461

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY ✓			
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 1yr3mth27days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3401-4			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First Jean Middle Sadie Last Caplan		4. DATE OF DEATH Month February Day 21 Year 19 57			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Sept 19, 1902	9. AGE (In years last birthday) 54 yrs.	IF UNDER 1 YEAR Months 54 Days 19 Hours 57 Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) seamstress		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Alex Whitesman				14. MOTHER'S MAIDEN NAME Rebecca Jacobs			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Internal Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic lesions of carcinoma of the sigmoid DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 26, 1956 , to Feb. 21, 1957 , that I last saw the deceased alive on Feb. 21, 1957 , and that death occurred at 5:20 a.m. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Stella Wachslar		M.D. SPRING GROVE STATE HOSPITAL		DATE SIGNED 2-21-57			
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		Catonsville, 28, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-22-57		22c. NAME OF CEMETERY OR CREMATORY Hebrew Young men		22d. LOCATION (City, town, or county) (State) Balto Md	
23. FUNERAL DIRECTOR'S SIGNATURE Jack Lewis Inc				ADDRESS 2100 Eustaw Place		24a. REC'D BY REGISTRAR FEB 25 '57	
				24b. REGISTRAR'S SIGNATURE Quisenberry			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
MARRIAGE		EDUCATION		OCCUPATION		RELIGION		MANNER OF DEATH		CAUSE OF DEATH		DISEASE		SYMPTOMS	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF INTERMENT		PLACE OF INTERMENT		CITY OF INTERMENT		COUNTRY OF INTERMENT	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF MINISTER		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF JUDGE		SIGNATURE OF CLERK	

BUREAU V. S.

FEB 25 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1465

CERTIFICATE OF DEATH

01462

Reg. Dist. No.

45

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rosedale</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>xo Rosedale</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7867 Oakdale Avenue</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mr. William T. Carter Sr.</u> Middle <u></u> Last <u></u>				4. DATE OF DEATH Month <u>February</u> Day <u>5th</u> Year <u>1957</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 28, 1884</u>		9. AGE (In years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Thomas Carter</u>				14. MOTHER'S MAIDEN NAME <u>Jane Warfel</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give war or dates of service) <u></u>		16. SOCIAL SECURITY NO. <u>218-10-6010</u>		17. INFORMANT Address <u>Mrs. Nannie M. Carter, 7867 Oakdale Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>163x Pulmonary hemorrhage</u> DUE TO <u>Cancer of Lung (Right)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u>						INTERVAL BETWEEN ONSET OF DEATH <u>10 minutes</u> <u>10 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		
			20f. (City or town) <u></u> (County) <u></u> (State) <u></u>				
21. I certify that I attended the deceased from <u>7-1</u> , 19 <u>56</u> , to <u>2/5</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2/5</u> , 19 <u>57</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u></u> DATE SIGNED <u></u>							
ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u></u>							
PHYSICIAN'S NAME (Type) <u>H. D. T. [Signature]</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/1/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Mem. Pk</u>		22d. LOCATION (City, town, or county) (State) <u>Elkridge, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard G. Ruck</u> ADDRESS <u>5305 Harford Road #14</u>				24a. REC'D BY REGISTRAR <u>FEB 12 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Edith [Signature]</u>	

FEB 13 1957

BUREAU V. S.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1466 CERTIFICATE OF DEATH

01463 44

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 71 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WINFIELD Middle R. Last CHESTER		4. DATE OF DEATH Month February Day 11 Year 1957	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 5, 1889
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		10b. KIND OF BUSINESS OR INDUSTRY Trucking	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William H. Chester		14. MOTHER'S MAIDEN NAME Mary Keys	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 150x IMMEDIATE CAUSE (a) CARCINOMA OF ESOPHAGUS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 7 MONTHS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 2, 1956 , to February 11, 1957 , that I have examined the deceased and that death occurred at 9:50 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED VAH, FORT HOWARD, MARYLAND 2/12/57			
ACTUAL SIGNATURE Irving Freeman M.D. VAH, FORT HOWARD, MARYLAND			
PHYSICIAN'S NAME (Type) IRVING FREEMAN, Chief, Medical Service, VAH, Ft. Howard, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/15/57	22c. NAME OF CEMETERY OR CREMATORY Baltimore National	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips, 1808 N. Monroe St. Balto. Md.		24a. REC'D BY REGISTRAR 2-13-57	
24b. REGISTRAR'S SIGNATURE Lawson L. Farley			

CERTIFICATE OF DEATH

1968

REG. NO. 10

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male	
3. DATE OF BIRTH May 19, 1928		4. PLACE OF BIRTH Jackson, Tennessee	
5. OCCUPATION None		6. MARITAL STATUS Single	
7. CAUSE OF DEATH Suicide		8. MANNER OF DEATH Homicide	
9. PLACE OF DEATH Baltimore, Maryland		10. DATE OF DEATH April 4, 1968	
11. SIGNATURE OF PHYSICIAN J. Edgar Hoover		12. SIGNATURE OF CORONER J. Edgar Hoover	
13. SIGNATURE OF REGISTRAR J. Edgar Hoover		14. SIGNATURE OF WITNESSES J. Edgar Hoover	
15. SIGNATURE OF DECEASED J. Edgar Hoover		16. SIGNATURE OF NEXT OF KIN J. Edgar Hoover	
17. SIGNATURE OF BURIAL OFFICIAL J. Edgar Hoover		18. SIGNATURE OF FUNERAL HOME J. Edgar Hoover	
19. SIGNATURE OF CHURCH OFFICIAL J. Edgar Hoover		20. SIGNATURE OF OTHER OFFICIAL J. Edgar Hoover	
21. SIGNATURE OF OTHER OFFICIAL J. Edgar Hoover		22. SIGNATURE OF OTHER OFFICIAL J. Edgar Hoover	
23. SIGNATURE OF OTHER OFFICIAL J. Edgar Hoover		24. SIGNATURE OF OTHER OFFICIAL J. Edgar Hoover	
25. SIGNATURE OF OTHER OFFICIAL J. Edgar Hoover		26. SIGNATURE OF OTHER OFFICIAL J. Edgar Hoover	
27. SIGNATURE OF OTHER OFFICIAL J. Edgar Hoover		28. SIGNATURE OF OTHER OFFICIAL J. Edgar Hoover	
29. SIGNATURE OF OTHER OFFICIAL J. Edgar Hoover		30. SIGNATURE OF OTHER OFFICIAL J. Edgar Hoover	
31. SIGNATURE OF OTHER OFFICIAL J. Edgar Hoover		32. SIGNATURE OF OTHER OFFICIAL J. Edgar Hoover	
33. SIGNATURE OF OTHER OFFICIAL J. Edgar Hoover		34. SIGNATURE OF OTHER OFFICIAL J. Edgar Hoover	
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53. SIGNATURE OF OTHER OFFICIAL J. Edgar Hoover		54. SIGNATURE OF OTHER OFFICIAL J. Edgar Hoover	
55. SIGNATURE OF OTHER OFFICIAL J. Edgar Hoover		56. SIGNATURE OF OTHER OFFICIAL J. Edgar Hoover	
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59. SIGNATURE OF OTHER OFFICIAL J. Edgar Hoover		60. SIGNATURE OF OTHER OFFICIAL J. Edgar Hoover	
61. SIGNATURE OF OTHER OFFICIAL J. Edgar Hoover		62. SIGNATURE OF OTHER OFFICIAL J. Edgar Hoover	
63. SIGNATURE OF OTHER OFFICIAL J. Edgar Hoover		64. SIGNATURE OF OTHER OFFICIAL J. Edgar Hoover	
65. SIGNATURE OF OTHER OFFICIAL J. Edgar Hoover		66. SIGNATURE OF OTHER OFFICIAL J. Edgar Hoover	
67. SIGNATURE OF OTHER OFFICIAL J. Edgar Hoover		68. SIGNATURE OF OTHER OFFICIAL J. Edgar Hoover	
69. SIGNATURE OF OTHER OFFICIAL J. Edgar Hoover		70. SIGNATURE OF OTHER OFFICIAL J. Edgar Hoover	
71. SIGNATURE OF OTHER OFFICIAL J. Edgar Hoover		72. SIGNATURE OF OTHER OFFICIAL J. Edgar Hoover	
73. SIGNATURE OF OTHER OFFICIAL J. Edgar Hoover		74. SIGNATURE OF OTHER OFFICIAL J. Edgar Hoover	
75. SIGNATURE OF OTHER OFFICIAL J. Edgar Hoover		76. SIGNATURE OF OTHER OFFICIAL J. Edgar Hoover	
77. SIGNATURE OF OTHER OFFICIAL J. Edgar Hoover		78. SIGNATURE OF OTHER OFFICIAL J. Edgar Hoover	
79. SIGNATURE OF OTHER OFFICIAL J. Edgar Hoover		80. SIGNATURE OF OTHER OFFICIAL J. Edgar Hoover	
81. SIGNATURE OF OTHER OFFICIAL J. Edgar Hoover		82. SIGNATURE OF OTHER OFFICIAL J. Edgar Hoover	
83. SIGNATURE OF OTHER OFFICIAL J. Edgar Hoover		84. SIGNATURE OF OTHER OFFICIAL J. Edgar Hoover	
85. SIGNATURE OF OTHER OFFICIAL J. Edgar Hoover		86. SIGNATURE OF OTHER OFFICIAL J. Edgar Hoover	
87. SIGNATURE OF OTHER OFFICIAL J. Edgar Hoover		88. SIGNATURE OF OTHER OFFICIAL J. Edgar Hoover	
89. SIGNATURE OF OTHER OFFICIAL J. Edgar Hoover		90. SIGNATURE OF OTHER OFFICIAL J. Edgar Hoover	
91. SIGNATURE OF OTHER OFFICIAL J. Edgar Hoover		92. SIGNATURE OF OTHER OFFICIAL J. Edgar Hoover	
93. SIGNATURE OF OTHER OFFICIAL J. Edgar Hoover		94. SIGNATURE OF OTHER OFFICIAL J. Edgar Hoover	
95. SIGNATURE OF OTHER OFFICIAL J. Edgar Hoover		96. SIGNATURE OF OTHER OFFICIAL J. Edgar Hoover	
97. SIGNATURE OF OTHER OFFICIAL J. Edgar Hoover		98. SIGNATURE OF OTHER OFFICIAL J. Edgar Hoover	
99. SIGNATURE OF OTHER OFFICIAL J. Edgar Hoover		100. SIGNATURE OF OTHER OFFICIAL J. Edgar Hoover	

BUREAU V. 2

FEB 14 1967

RECEIVED

1467

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 19 Hours	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHARLES Middle H. Last CHRISTNER		4. DATE OF DEATH Month February Day 13 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 22, 1892
9. AGE (In years last birthday) yrs. 64		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Night Watchman		10b. KIND OF BUSINESS OR INDUSTRY Construction Co.	
11. BIRTHPLACE (State or foreign country) Brownsville, Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Frank G. Christner		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 420.0 DUE TO ARTERIOSCLEROTIC CORONARY THROMBOSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO ARTERIOSCLEROTIC HEART DISEASE (c)		INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS UNKNOWN UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1:30 PM		20f. (City or town) (County) (State) 8:30 AM	
21. I certify that I attended the deceased from February 12, 19 57 , to February 13, 19 57 , and that death occurred at 8:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Irving Freeman</i>		ADDRESS (Street, city or town, state) DATE SIGNED VAH, FORT HOWARD, MARYLAND 2/13/57	
PHYSICIAN'S NAME (Type) IRVING FREEMAN, M.D., Chief, Medical Service, VAH, Fort Howard, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 2-15-57	
22c. NAME OF CEMETERY OR CREMATORY Redstone Cemetery		22d. LOCATION (City, town, or county) (State) Fayette County, Pennsylvania	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm Cook-Blight, Inc</i>		24a. REC'D BY REGISTRAR 2-18-57	
ADDRESS Wm. Cook-Blight, Inc., 6009 Harford Rd., Balto. 14, Md.		24b. REGISTRAR'S SIGNATURE <i>Dawson L. Farley</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01465

1468

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 1 Mos			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House in the Pines Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Howard Middle L. Last Cochran				4. DATE OF DEATH Month Feb. Day 17, Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 18, 1887	9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Conductor		10b. KIND OF BUSINESS OR INDUSTRY Md. & Pa. R.R.		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Cochran				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 705-10-8810		17. INFORMANT Mrs. Mary T. Cochran Address 2708 Huntingdon Ave			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chs. Hypertensive Cardio-Vascular. Blood Disease DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 2 wks. 10 yrs (?)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED White at work <input type="checkbox"/> Nat white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Catonsville	(County) Md.	(State) Md.		
21. I certify that I attended the deceased from 1-15 , 1957, to 2-17 , 1957, that I last saw the deceased alive on 2-16 , 1957, and that death occurred at 9:58 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6209 Frederick Ave. Catonsville-28, Md. DATE SIGNED 2-18-57 ACTUAL SIGNATURE Wilmer K. Gallagher M.D. PHYSICIAN'S NAME (Type) Wilmer K. Gallagher, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-20-1957	22c. NAME OF CEMETERY OR CREMATORY St. John's	22d. LOCATION (City, town, or county) Long Green, Md.	(State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Edward Strong			ADDRESS 3677 North Ave	24a. REC'D BY REGISTRAR DATE 2/19/57	24b. REGISTRAR'S SIGNATURE W. H. Hedrick		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

FEB 20 1957

BUREAU V. A.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01466

1469

CERTIFICATE OF DEATH

Reg. Dist. No.

33

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OWINGS MILLS, MD.</u>		c. LENGTH OF STAY IN 1b <u>19 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ROSEWOOD TRAINING SCHOOL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Paul CONNERS</u>		4. DATE OF DEATH Month Day Year <u>FEB. 17 1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-31-30</u>
9. AGE (In years last birthday) <u>26</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>EKTON, Cecil Co., MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>UNITED STATES</u>	
13. FATHER'S NAME <u>William Paul CONNERS Sr.</u>		14. MOTHER'S MAIDEN NAME <u>ANNA FRANKLIN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT (FATHER) Address <u>William Paul CONNERS NORTHEAST, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHO - PNEUMONIA</u> DUE TO (b) <u>CEREBRAL SPASTIC, INFANTILE PARALYSIS</u> DUE TO (c) <u>EPILEPSY</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH <u>10 DAYS - BIRTH</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>FEB. 16</u> , 19 <u>57</u> , to <u>FEB. 17</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11:30 PM 2-16</u> , 19 <u>57</u> , and that death occurred at <u>4:25 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. B. Butler</u>		DATE SIGNED <u>Feb 19 1957</u>	
PHYSICIAN'S NAME (Type)		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-20-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St Mary Anne</u>		22d. LOCATION (City, town, or county) (State) <u>North East Cecil Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R Grant</u>		24a. REC'D BY REGISTRAR <u>FEB 19 1957</u>	
ADDRESS <u>North East Md</u>		24b. REGISTRAR'S SIGNATURE <u>Mary Cling</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

1488

Date of Birth

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES EARL RAY		MALE		35		1922		MOBILE, ALABAMA		MOBILE		ALABAMA		UNITED STATES	
FATHER'S NAME		MOTHER'S NAME		FATHER'S OCCUPATION		MOTHER'S OCCUPATION		FATHER'S PLACE OF BIRTH		MOTHER'S PLACE OF BIRTH		FATHER'S CITY		MOTHER'S CITY	
JAMES EARL RAY		LUCY ANN RAY		FARMER		HOUSEWIFE		MOBILE, ALABAMA		MOBILE, ALABAMA		MOBILE		MOBILE	
EDUCATION		RELIGION		MARRIAGE DATE		MARRIAGE PLACE		MARRIAGE STATE		MARRIAGE COUNTRY		MARRIAGE CITY		MARRIAGE STATE	
HIGH SCHOOL		METHODIST		1945		MOBILE, ALABAMA		ALABAMA		UNITED STATES		MOBILE		ALABAMA	
PREVIOUS ILLNESS		CAUSE OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		CITY OF DEATH	
NONE		HEART DISEASE		4/4/68		MOBILE, ALABAMA		MOBILE		ALABAMA		UNITED STATES		MOBILE	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH	
4/4/68		MOBILE, ALABAMA		MOBILE		ALABAMA		UNITED STATES		MOBILE		ALABAMA		UNITED STATES	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH	
4/4/68		MOBILE, ALABAMA		MOBILE		ALABAMA		UNITED STATES		MOBILE		ALABAMA		UNITED STATES	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1470 Item 8 Film 210 2-18-57 et

Reg. Dist. No.

01467
38

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Carney		c. LENGTH OF STAY IN lb 50yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2601 Cub Hill Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GUY Middle Franklin Last COOK		4. DATE OF DEATH Month February Day 7 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 30, 1898 1896
9. AGE (in years last birthday) 61 yrs.		10. IF UNDER 1 YEAR Months 61 Days 7 Hours 19 Min. 57	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Real Estate Broker		10b. KIND OF BUSINESS OR INDUSTRY Real Estate	
11. BIRTHPLACE (State or foreign country) Edinburg Va.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William Cook		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) WW1		16. SOCIAL SECURITY NO. 216-12-6949	
17. INFORMANT Mrs. Marie C. Cook		Address 2535 Greenmount Ave. 18	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease. 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE William V. Lovitt, Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 2/8/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 11/57	
22c. NAME OF CEMETERY OR CREMATORY Balto. Nat. Cem		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Philip Henry Low		ADDRESS 2024 Orleans St. 31	
24a. REC'D BY REGISTRAR DATE 2-13-57		24b. REGISTRAR'S SIGNATURE Dr. A. M. Bacon	

MEDICAL CERTIFICATION

2

ILLINOIS STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death	
John Doe		Male		35		10-15-57	
Place of Birth		Usual Residence		Cause of Death		Manner of Death	
Chicago, Ill.		Chicago, Ill.		Heart Disease		Natural	
Occupation		Education		Marital Status		Previous Illnesses	
Teacher		High School		Married		None	
Signature of Physician		Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	
[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. 2

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may be retained by the hospital, or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 12 Film G211 2-20-57 et

CERTIFICATE OF DEATH

01468

Reg. Dist. No.

Item 8, 9 = G210 2/13/1474

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Parkville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2530 Hillcrest Avenue</u>				d. STREET ADDRESS <u>1 2530 Hillcrest Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mrs. Mary Elizabeth Corcoran</u>				4. DATE OF DEATH Month Day Year <u>February 8th 19 57</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 6, 1887</u>	9. AGE (In years last birthday) <u>70 6/7</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>England</u>	
13. FATHER'S NAME <u>John Birchenough</u>				14. MOTHER'S MAIDEN NAME <u>Martha Chadwick</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>2530 Hillcrest Av</u> <u>Mr. Joseph Edward Corcoran</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of stomach with metastasis</u> 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>3 yr +</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1952</u> , 19____, to <u>2-8-57</u> , 19____, that I last saw the deceased alive on <u>2-7-57</u> , 19____, and that death occurred at <u>12:39 M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. V. Rangle M.D.</u> M.D. <u>2938 J St</u> DATE SIGNED <u>2-8-57</u>				ADDRESS (Street, city or town, state) <u>Bulk. 18, Md</u>			
PHYSICIAN'S NAME (Type) <u>R. V. Rangle M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/13/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Sepulchre Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Paterson, New Jersey</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Leonard J. Ruck 5305 Harford Road #14</u>				24a. REC'D BY REGISTRAR DATE <u>2-13-57</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. A. M. Baran</u>	

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>526 Catonsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Shadybrook Convalescent Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>E.</u> Last <u>Coughlan</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>6</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/12/1874</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales Lady</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Goldstein Bros</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Patrick Coughlan</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Mrs Elizabeth B. E. Eubart</u>		Address <u>818 Mt Holly St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>Arterio sclerosis</u> DUE TO <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Myocarditis severe</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 hr -</u> <u>years</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>422.1</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug</u> , 19 <u>56</u> to <u>Feb 6</u> , 19 <u>57</u> that I last saw the deceased alive on <u>Feb 4</u> , 19 <u>57</u> , and that death occurred at <u>11:57 AM</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <u>W. B. D. Fort</u> M.D. <u>1118 St. Paul St.</u>		PHYSICIAN'S NAME (Type) <u>Wetherbee Fort</u> <u>1118 St. Paul St. Balt. 2</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/9/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>4300 Old Frederick Rd.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Cowan</u>		ADDRESS <u>901 Holling St.</u>	
24a. REC'D BY REGISTRAR DATE <u>FEB 8 '57</u>		24b. REGISTRAR'S SIGNATURE <u>W. B. D. Fort</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01470

1473

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riderwood		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Riderwood	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1723 Joppa Road		d. STREET ADDRESS 1723 Joppa Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) NETTIE JANE COX		4. DATE OF DEATH Month February Day 10 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 20, 1874
9. AGE (In years last birthday) yrs. 82		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ephriam B. Morris		14. MOTHER'S MAIDEN NAME Susan C. Prim	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Family Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JANUARY, 1954 , to February, 1957 , that I last saw the deceased alive on December 12, 1956 , and that death occurred at 12:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE B. X. Quinn M.D. 1927 York Rd. Timonium 2-12-57		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) M. KEVIN QUINN		Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 13, 1957	
22c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery		22d. LOCATION (City, town, or county) (State) Freeland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons		24a. REC'D BY REGISTRAR Feb. 12, 1957	
ADDRESS Towson, Md.		24b. REGISTRAR'S SIGNATURE Mabel C. Gray	

CERTIFICATE OF DEATH

Attorney

BUREAU V. 2

22 14 1957

RECEIVED

1474

CERTIFICATE OF DEATH

Reg. Dist. No.

37

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville		c. LENGTH OF STAY IN 1b life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Warren Rd.		d. STREET ADDRESS 1 Warren Rd/	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Mary Alberta Curtis		4. DATE OF DEATH Month Day Year 2-10-57 19	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-9-1867
9. AGE (In years last birthday) 90 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob Williams		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Wm. Harrison Curtis, Cockeysville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 199.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October, 1956 , to Feb. 8th, 1957 , that I last saw the deceased alive on Feb. 8th, 1957 , and that death occurred at 6:30 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE M. X. Quinn		DATE SIGNED 1927 YORK Rd TIMONIUM, Md. 2-11-57	
PHYSICIAN'S NAME (Type) M. KEVIN QUINN MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-13-57	
22c. NAME OF CEMETERY OR CREMATORY Poplar Grove		22d. LOCATION (City, town, or county) (State) Cockeysville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Scott Brooks		ADDRESS Towson 4, Md.	
24a. REC'D BY REGISTRAR DATE 2/14/57		24b. REGISTRAR'S SIGNATURE Wm. J. Whitcomb	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

01472

1475

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 4 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 234 Glenmore Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Elizabeth Middle M. Last Devan		4. DATE OF DEATH Month Feb. Day 7 Year 19 57	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 4, 1872
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired School Teacher, Balto. City		10b. KIND OF BUSINESS OR INDUSTRY Md.	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Devan		14. MOTHER'S MAIDEN NAME Mary Kyne	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Miss Martha Devan, Elkridge Md.	
17. INFORMANT Miss Martha Devan, Elkridge Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thromboses 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) Atherosclerosis, generalized, severe Interval between onset and death 72 hrs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Unknown			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. 19 p. m. Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-4 , 19 57 to 2-6 , 19 57 , that I last saw the deceased alive on 2-6 , 19 57 , and that death occurred at 9:15 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, State) 908 Frederick Rd, Catonsville DATE SIGNED 2-5-57			
ACTUAL SIGNATURE Stephen Lee Magness M.D.		PHYSICIAN'S NAME (Type) STEPHEN LEE MAGNESS	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 9/57	
22c. NAME OF CEMETERY OR CREMATORY St. Augustine Cem.		22d. LOCATION (City, town, or county) (State) Elkridge Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Harry H. Witzke, 4101 Edmondson Ave.		24a. REC'D BY REGISTRAR DATE FEB 11 57	
24b. REGISTRAR'S SIGNATURE Overman			

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the registrar should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01473

1476

CERTIFICATE OF DEATH

Reg. Dist. No.

21

1. PLACE OF DEATH o. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE 7</u>	c. LENGTH OF STAY IN 1b <u>6 MOS.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE 7</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8319 LIBERTY ROAD</u>		d. STREET ADDRESS <u>8319 LIBERTY ROAD</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>PAUL MARION DIGGINS</u>		4. DATE OF DEATH Month Day Year <u>FEB 2 1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 14 1895</u>
9. AGE (In years last birthday) <u>61</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CREDIT MGR.</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>ACCOUNTING</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>CORNELIUS J. DIGGINS</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
14. MOTHER'S MAIDEN NAME <u>HELENIA CUSHING</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>MRS PAUL DIGGINS - 8319 LIBERTY RD - MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA RECTUM & GENERAL.</u> <u>154X</u> DUE TO <u>CARCINOMATOSIS -</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>443X</u> (b) <u>CEREBRAL VASCULAR ACCIDENT &</u> (c) <u>PARALYSIS -</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 YEAR</u> <u>7 YEARS</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>HYPERTENSIVE C.V. DISEASE - SEVERE</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>NOV 1 1956</u> , to <u>FEB 2 1957</u> , that I last saw the deceased alive on <u>FEB 2 1957</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>3601 CUPPARD RD - BALTO 7 - MD</u> DATE SIGNED <u>2/2/57</u> ACTUAL SIGNATURE <u>Thomas E. Wheeler MD</u> PHYSICIAN'S NAME (Type) <u>THOMAS E. WHEELER</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Feb. 5, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Dr. Vernon Lemmon</u>		24a. REC'D BY REGISTRAR <u>Dr. Jm. Masterson</u>	
24b. REGISTRAR'S SIGNATURE <u>Dr. Jm. Masterson</u>		24c. DATE <u>FEB 4 1957</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH	
JAMES H. HARRIS		45		M		W		1912		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		1957		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
MARRIED		YES		YES		YES		YES		YES		YES		YES		YES		YES		YES		YES		YES		YES	
EDUCATION		HIGH SCHOOL		HIGH SCHOOL		HIGH SCHOOL		HIGH SCHOOL		HIGH SCHOOL		HIGH SCHOOL		HIGH SCHOOL		HIGH SCHOOL		HIGH SCHOOL		HIGH SCHOOL		HIGH SCHOOL		HIGH SCHOOL		HIGH SCHOOL	
OCCUPATION		LABORER		LABORER		LABORER		LABORER		LABORER		LABORER		LABORER		LABORER		LABORER		LABORER		LABORER		LABORER		LABORER	
CAUSE OF DEATH		HEART DISEASE		HEART DISEASE		HEART DISEASE		HEART DISEASE		HEART DISEASE		HEART DISEASE		HEART DISEASE		HEART DISEASE		HEART DISEASE		HEART DISEASE		HEART DISEASE		HEART DISEASE		HEART DISEASE	
MANNER OF DEATH		NATURAL		NATURAL		NATURAL		NATURAL		NATURAL		NATURAL		NATURAL		NATURAL		NATURAL		NATURAL		NATURAL		NATURAL		NATURAL	
SIGNATURE OF PHYSICIAN		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	
SIGNATURE OF REGISTRAR		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01474

1477

CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD, MD.				c. LENGTH OF STAY IN 1b 7 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Sr. FRANK P DOORY				4. DATE OF DEATH Month Day Year February 9 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/23/95	
9. AGE (In years last birthday) yrs. 61		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John T. Doory				14. MOTHER'S MAIDEN NAME Annie Proctor			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 212-05-4550		17. INFORMANT Address Clin. Rec., Vet. Adm. Hosp. Ft. Howard, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA LEFT UPPER LOBE & RIGHT MIDDLE AND LOWER LOBES 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ADVANCED EMPHYSEMA OF LUNG, BILATERAL							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from February 2, 1957 , to February 9, 1957 , that I last saw the deceased alive on February 9, 1957 , and that death occurred at 4:20 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, Fort Howard, Maryland DATE SIGNED 2/10/57 ACTUAL SIGNATURE Rolando D. Ponce de Leon M.D. PHYSICIAN'S NAME (Type) ROLANDO D. PONCE DE LEON, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 13, 1957		22c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Schimunek Funeral Home, 2601 E. Madison St Baltimore, Md.				24a. REC'D BY REGISTRAR DATE 2-13-57		24b. REGISTRAR'S SIGNATURE Darwin L. Fisher	

CERTIFICATE OF DEATH

BUREAU V. 2

FEB 14 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

01475

1478

CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 27 Days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewater 02X12				d. STREET ADDRESS Box 124 Route #2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle E. Last DORSEY				4. DATE OF DEATH Month February Day 6 Year 1957			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 12, 1890		9. AGE (In years last birthday) yrs. 66	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Owner of farm		11. BIRTHPLACE (State or foreign country) Parole, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME James Dorsey				14. MOTHER'S MAIDEN NAME Rachel Tydings			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give year or dates of service) WW I		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Clin. Rec. Vet. Administration Hospital, Ft. Howard, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CIRRHOSIS OF LIVER 289.2 DUE TO HEMOCHROMATOSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 6 YEARS
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from January 10, 1957 to February 6, 1957 and that death occurred at 7:45P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) VA HOSPITAL, FORT HOWARD, MARYLAND DATE SIGNED 2/7/57							
ACTUAL SIGNATURE Rolando D. Ponce de Leon M.D. VA HOSPITAL, FORT HOWARD, MARYLAND							
PHYSICIAN'S NAME (Type) ROLANDO D. PONCE de LEON VAH, FORT HOWARD, MARYLAND							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-12-57		22c. NAME OF CEMETERY OR CREMATORY Annapolis, National Cem.		22d. LOCATION (City, town, or county) (State) Annapolis, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Reese Funeral Home, Washington St., Annapolis, Md.				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE Dawson L. Farkes	

FEB 18 1957

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

1957

NAME OF DECEASED		DATE OF DEATH	
JAMES J. JONES		FEBRUARY 18, 1957	
AGE		SEX	
35 YEARS		MALE	
RACE		COLOR	
WHITE		WHITE	
BIRTHPLACE		MARRIAGE	
BALTIMORE, MARYLAND		MARRIED	
OCCUPATION		CAUSE OF DEATH	
LABORER		HEART DISEASE	
EDUCATION		MANNER OF DEATH	
HIGH SCHOOL		NATURAL	
RELIGION		PLACE OF DEATH	
METHODIST		HOME	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
JAMES J. JONES		JAMES J. JONES	
DATE		DATE	
FEBRUARY 18, 1957		FEBRUARY 18, 1957	

BUREAU V. S.

FEB 18 1957

RECEIVED

1479

CERTIFICATE OF DEATH

Reg. Dist. No.

45

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosedale		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosedale	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1901 Summit Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First KUNIGUNDA Middle DRUMMER Last		4. DATE OF DEATH Month FEBRUARY Day 16 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 27, 1867
9. AGE (In years last birthday) yrs. 89		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ? ALT		14. MOTHER'S MAIDEN NAME ? ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT William L. Drummer		Address 1901 Summit Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio-sclerotic C.V.D. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH 10 minutes 30 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/11, 1957 , to 2/16, 1957 , that I last saw the deceased alive on 2/15, 1957 , and that death occurred at 2:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5829 Belair Rd DATE SIGNED 2/18/57			
ACTUAL SIGNATURE D. T. Battaglia		M.D. 5829 Belair Rd	
PHYSICIAN'S NAME (Type) Dr. D.T. Battaglia			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb 18, 1957	
22c. NAME OF CEMETERY OR CREMATORY St. Matthews Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John A. Moran		24a. REC'D BY REGISTRAR Edith H. Bailey	
24b. REGISTRAR'S SIGNATURE Edith H. Bailey		DATE FEB 20 1957	

CERTIFICATE OF DEATH

Page 1 of 1

<p>1. Name of Deceased ROOSEDALE, JAMES</p>		<p>2. Date of Birth 1901</p>	
<p>3. Sex Male</p>		<p>4. Race White</p>	
<p>5. Marital Status Married</p>		<p>6. Date of Death 1957</p>	
<p>7. Cause of Death Heart Disease</p>		<p>8. Place of Death Home</p>	
<p>9. Signature of Physician Dr. J. H. Heston</p>		<p>10. Signature of Registrar John A. Jones</p>	
<p>11. Date of Burial 1957</p>		<p>12. Place of Burial Home</p>	
<p>13. Signature of Coroner John A. Jones</p>		<p>14. Signature of Medical Examiner John A. Jones</p>	

BUREAU V. A.

FEB 20 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

45

1480

1. PLACE OF DEATH o. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - BALTIMORE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - BALTIMORE</u>			
c. LENGTH OF STAY IN 1b <u>14 YRS.</u>				d. STREET ADDRESS <u>1114 ROSDALE AVE.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1114 ROSDALE AVE.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARTHA</u> Middle <u>JENNY</u> Last <u>DUTTERER</u>				4. DATE OF DEATH Month <u>FEB.</u> Day <u>20</u> Year <u>1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-22-1885</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>CARROLL CO. MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>NOAH HOLLINGER</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET KAUFMAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NO</u>			
17. INFORMANT <u>John W. Dutterer</u> Address <u>1114 Rosedale Ave. #6, Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>48 HOURS</u> <u>10 YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>JUNE</u> , 19 <u>53</u> , to <u>FEB</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>FEB 19</u> , 19 <u>57</u> , and that death occurred at <u>2:30 A.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>James R. Mason, M.D.</u>				M.D. <u>5019 DITKALSKY RD.</u>			
PHYSICIAN'S NAME (Type) <u>JAMES R. MASON</u>				<u>BALTIMORE 6, MARYLAND</u> <u>CARROLL CO.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2-22-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST. MARY'S-CEM. SILVER POIN</u>		22d. LOCATION (City, town, or county) (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard A. Little</u> Address <u>Littlestown PA</u>				24a. REC'D BY REGISTRAR <u>Edith Hurley</u>		24b. REGISTRAR'S SIGNATURE <u>Edith Hurley</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form No. 101

RECEIVED
FEB 21 1957
BUREAU V. S.

<p>1. Name of deceased: _____</p>	
<p>2. Sex: _____</p>	
<p>3. Age: _____</p>	
<p>4. Date of death: _____</p>	
<p>5. Place of death: _____</p>	
<p>6. Cause of death: _____</p>	
<p>7. Signature of physician: _____</p>	
<p>8. Signature of registrar: _____</p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01478

1481

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville 28,		c. LENGTH OF STAY IN 1b 55 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2542 Old Frederick Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LAWRENCE Middle WILLIAM Last DYSON		4. DATE OF DEATH Month February Day 2, Year 1957.	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 24, 1901.
9. AGE (In years last birthday) 55 yrs.		10. IF UNDER 1 YEAR: Months 55 Days 55 Hours 55 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Gasoline Pump Installer	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lawrence Dyson		14. MOTHER'S MAIDEN NAME Annie Clark	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-07-2059	
17. INFORMANT Mrs. Annie M. Teale		Address 2542 Old Frederick Road Catonsville 28, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Arteriosclerosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH 4 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 30 , 19 57 , to Feb 2 , 19 57 , that I last saw the deceased alive on Feb 2 , 19 57 , and that death occurred at 11 A .M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Man St DATE SIGNED Ellicott City Md			
ACTUAL SIGNATURE Dr. L.A. Kochman M.D.		PHYSICIAN'S NAME (Type) Ellicott City Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Feb. 5, 1957.	22c. NAME OF CEMETERY OR CREMATORY Good Shepherd Cemetery	22d. LOCATION (City, town, or county) (State) Ellicott City, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Easton Sons, Catonsville 28, Md.		24a. REC'D BY REGISTRAR DATE FEB 5 '57	
24b. REGISTRAR'S SIGNATURE W. L. Smith			

BUREAU V. S.

FEB 5 1957

RECEIVED

1482

CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
c. LENGTH OF STAY IN 1b 6 Years		x2 Balto. Co. Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3519 Joppa Rd.		d. STREET ADDRESS 3519 Joppa Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Jacob Middle W. Last Ellinger		4. DATE OF DEATH Month 2 Day 8 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1867 Nov. 22, 1867
9. AGE (In years last birthday) 89 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Blacksmith retired		10b. KIND OF BUSINESS OR INDUSTRY B&O R.R.	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Hillbinger		Address 3519 Joppa Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 10 yrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from March , 19 48 , to Feb 8 , 19 57 , that I last saw the deceased alive on Feb 8 , 19 57 , and that death occurred at 1:30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6217 Harford Rd Baltimore 14 DATE SIGNED 2/8/57			
ACTUAL SIGNATURE E. J. Alessi		M.D. 6217 Harford Rd Baltimore 14	
PHYSICIAN'S NAME (Type) E. J. Alessi, M. D.		6217 Harford Road Baltimore 14, Md. 2/8/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/11/57	22c. NAME OF CEMETERY OR CREMATORY Parkwood	22d. LOCATION (City, town, or county) (State) Balto. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Lorraine Funk Horns		24. REG'D BY REGISTRAR FEB 11 1957	
ADDRESS 7401 Belair Rd.		24b. REGISTRAR'S SIGNATURE Michael Gray	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01480

1483

CERTIFICATE OF DEATH

Reg. Dist. No.

33

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY P.G.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills, Maryland				c. LENGTH OF STAY IN 1b 20 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood State Training School				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Frank Fairfield Eskite				4. DATE OF DEATH Month Day Year February 14, 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/16/22	9. AGE (In years last birthday) 34 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Eskite				14. MOTHER'S MAIDEN NAME Helen Fairfield			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. -----		17. INFORMANT Address Rosewood Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe swelling of brain 193X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) glioma (astrocytoma) in right temporal lobe. DUE TO (c) ----- PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ----- INTERVAL BETWEEN ONSET AND DEATH						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 13, 19 57 , to February 14, 19 57 , that I last saw the deceased alive on February 14, 19 57 , and that death occurred at 2:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Rich. E. [Signature] M.D.				PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb 16, 1957		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Finnis Lusk Sons 144 Attleboro, Md.				24a. REC'D BY REGISTRAR DATE FEB 18 1957		24b. REGISTRAR'S SIGNATURE Mary Elise	

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, possibly "John Doe"]		SEX [Faint text, possibly "Male"]	
AGE [Faint text, possibly "45 years"]		DATE OF BIRTH [Faint text, possibly "Jan 15, 1910"]	
PLACE OF BIRTH [Faint text, possibly "Baltimore, Md."]		OCCUPATION [Faint text, possibly "Teacher"]	
CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		MANNER OF DEATH [Faint text, possibly "Natural"]	
TIME OF DEATH [Faint text, possibly "10:30 AM"]		PLACE OF DEATH [Faint text, possibly "Home"]	
SIGNATURE OF PHYSICIAN [Faint signature]		SIGNATURE OF REGISTRAR [Faint signature]	
DATE [Faint text, possibly "Feb 18, 1957"]		PLACE [Faint text, possibly "Baltimore, Md."]	

BUREAU V. S.

FEB 18 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01481

1484

CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 20 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHARLES Middle P. Last EVERSFIELD		4. DATE OF DEATH Month February Day 4 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 11, 1887
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician Foreman		10b. KIND OF BUSINESS OR INDUSTRY Contract Electrical work	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Edward W. Eversfield		14. MOTHER'S MAIDEN NAME Emily K. Pracht	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes If yes, give war or dates of service WW I		16. SOCIAL SECURITY NO. 216-09-5075	
17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF LEFT LUNG WITH METASTASES 163x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 1 YEAR	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that VA attended the deceased from January 15, 1957 , to February 4, 1957 , and that death occurred at 6:00 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Irving Freeman		M.D. VAH, FORT HOWARD, MARYLAND DATE SIGNED 2/4/57	
PHYSICIAN'S NAME (Type) IRVING FREEMAN, M.D., Chief, Medical Service, VAH, Fort Howard, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/7/57	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tickner & Sons, Inc., Baltimore, Maryland		24a. REC'D BY REGISTRAR DATE 2-5-57	
24b. REGISTRAR'S SIGNATURE Dawson K. Farley			

CERTIFICATE OF DEATH

<p>1. Name of deceased: CHARLES</p>		<p>2. Sex: Male</p>	
<p>3. Date of birth: April 11, 1887</p>		<p>4. Place of birth: Illinois</p>	
<p>5. Date of death: April 11, 1957</p>		<p>6. Place of death: Illinois</p>	
<p>7. Cause of death: Heart disease</p>		<p>8. Manner of death: Natural</p>	
<p>9. Signature of physician: Dr. J. H. Smith</p>		<p>10. Signature of registrar: John A. Smith</p>	
<p>11. Signature of informant: John A. Smith</p>		<p>12. Address of informant: 123 Main St, Chicago, Ill.</p>	
<p>13. Date of registration: April 11, 1957</p>		<p>14. Place of registration: Chicago, Ill.</p>	
<p>15. Registrar's signature: John A. Smith</p>		<p>16. Registrar's title: Registrar</p>	
<p>17. Date of filing: April 11, 1957</p>		<p>18. Place of filing: Chicago, Ill.</p>	
<p>19. Filing officer's signature: John A. Smith</p>		<p>20. Filing officer's title: Filing Officer</p>	

RECEIVED
FEB 6 1957
BUREAU V. S.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1485

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 214 Bloomsbury Ave.		d. STREET ADDRESS 214 Bloomsbury Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle Feast Last Feast		4. DATE OF DEATH Month Feb. Day 23 Year 1957	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 20, 1864
9. AGE (In years last birthday) 93 yrs.		IF UNDER 1 YEAR Months 27 Days 2 Hours 15 Min.	IF UNDER 24 HRS. Months 27 Days 2 Hours 15 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retail Florist		10b. KIND OF BUSINESS OR INDUSTRY Florist	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? Md.	
13. FATHER'S NAME John E. Feast		14. MOTHER'S MAIDEN NAME Mary J. Neily	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Miss Flora Feast		Address 214 Bloomsbury Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Myocardial Insufficiency (c) Ch. Hypertensive Cardio. Vascular Renal Disease		INTERVAL BETWEEN ONSET AND DEATH 1 w. 2 d. 27 d. 15 y. 7.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-2-57 , to 2-23-57 , that I last saw the deceased alive on 2-22-57 , and that death occurred at 3:40 M, from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE Wm. K. Gallagher M.D.		6209 Frederick Bv.	
PHYSICIAN'S NAME (Type) Wm. K. Gallagher		Catonsville-28, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-26-57	22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.	22d. LOCATION (City, town, or county) (State) Balto. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Julius Funeral Home - Catonsville, Md.		24a. REC'D BY REGISTRAR DATE MAR 1 '57	
24b. REGISTRAR'S SIGNATURE Q. Leach			

CERTIFICATE OF DEATH

1957

NAME OF DECEASED		DATE OF BIRTH		PLACE OF BIRTH	
SEX		RACE		EDUCATION	
MARRIED		OCCUPATION		CIVIL STATUS	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		DISEASE OR INJURY		IMMEDIATE CAUSE	
INTERVIEWED		WITNESSES		SIGNATURE OF DECEASED	
DATE OF INTERVIEW		PLACE OF INTERVIEW		SIGNATURE OF WITNESSES	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		DISEASE OR INJURY		IMMEDIATE CAUSE	
INTERVIEWED		WITNESSES		SIGNATURE OF DECEASED	
DATE OF INTERVIEW		PLACE OF INTERVIEW		SIGNATURE OF WITNESSES	

BUREAU V. 3

MAR 1 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with
the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01483

1486

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD, MARYLAND				c. LENGTH OF STAY IN 1b 26 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) Veterans Administration Hospital				d. STREET ADDRESS 4429 Clifton Road			
3. NAME OF DECEASED (Type or print) First Middle Last FRED W. FITZPATRICK				4. DATE OF DEATH Month Day Year February 10 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/4/91	9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tool Maker				10b. KIND OF BUSINESS OR INDUSTRY Tool & Die Co		11. BIRTHPLACE (State or foreign country) England	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME James Fitzpatrick				14. MOTHER'S MAIDEN NAME Elizabeth Woodhead			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 216-28-7081		17. INFORMANT Address Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA, RIGHT LOWER LOBE & LEFT UPPER LOBE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 490X (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH UNKNOWN
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CIRRHOSIS OF THE LIVER ARTERIOSCLEROSIS CORONARY ARTERIES, ADVANCED ANEURYSM OF THE ABDOMINAL AORTA. EMBOLUS LOWER POLE SPLEEN							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 15, 1957 , to February 10, 1957 , that I saw the deceased alive on February 10, 1957 , and that death occurred at 10 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Rolando D. Ponce de Leon M.D.				ADDRESS (Street, city or town, state) VAH, Fort Howard, Md.		DATE SIGNED 2/10/57	
PHYSICIAN'S NAME (Type) ROLANDO D. PONCE DE LEON, MD.				ADDRESS VAH, Fort Howard, Md.		DATE 2-10-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-13-57		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cock-Blight Inc. Funeral Home 6009 Harford Rd., Baltimore 14, Md.				24a. REC'D BY REGISTRAR FEB 13 1957		24b. REGISTRAR'S SIGNATURE Lawson L. Lacey	

RECEIVED

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1487

CERTIFICATE OF DEATH

01484

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Colgate</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Colgate</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7124 Eastbrook Avenue</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Miss Sarah A.</u> Middle <u>Flaherty</u> Last				4. DATE OF DEATH Month <u>February</u> Day <u>18th</u> Year <u>1957</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 9, 1880</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>George T. Flaherty</u>		14. MOTHER'S MAIDEN NAME <u>Ellen O'Conor</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Emma Isenrock, 7124 Eastbrook Ave</u> <u>Mrs. M. J. Jink</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial failure</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic arterial hypertension</u> DUE TO (c) <u>arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>years?</u> <u>years?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Feb 7</u> , 19 <u>57</u> , to <u>Feb 18</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Feb 18</u> , 19 <u>57</u> , and that death occurred at <u>9:30 p. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>George D. Lippy</u>				ADDRESS (Street, city or town, state) <u>4668 Patterson St. Baltimore, Md</u>			
PHYSICIAN'S NAME (Type) <u>George D. Lippy</u>				DATE SIGNED <u>Feb 21 1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/21/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>				ADDRESS <u>5305 Harford Road #14</u>		24a. REC'D BY REGISTRAR <u>Edith Harley</u>	
24b. REGISTRAR'S SIGNATURE				DATE <u>FEB 20 1957</u>			

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01485

Reg. Dist. No.

43

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
c. LENGTH OF STAY IN 1b <u>7 yrs</u>		d. STREET ADDRESS <u>5809 Farnview Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5809 Farnview Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>FRANCIS</u> ^{first} <u>Harry</u> ^{last} <u>Francis</u> ^{Middle}		4. DATE OF DEATH <u>Sept 15-1911</u> Month <u>2</u> Day <u>3</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 15-1911</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Eng Bldg RR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bldg-RR</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harry Francis</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-05-3631</u>	
17. INFORMANT <u>Mrs Anna Francis</u>		Address <u>5809 Farnview Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARBON Monoxide Poisoning -</u> <u>973.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>AUTO EXHAUST FUMES</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>FOUND DEAD IN CAR - MOTOR RUNNING</u>	
20c. TIME OF INJURY Month, Day, Year <u>5-2-3-1957</u> Hour <u>5</u> o. m. <u>2-3-1957</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>STREET</u>	20f. (City or town) <u>Baltimore Co. MD</u> (County) (State)
21. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined <input type="checkbox"/> <u>NATURAL</u> <u>McMURR</u>			
ACTUAL SIGNATURE <u>Russell S Fisher</u> M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Russell S Fisher</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/7/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood</u>		22d. LOCATION (City, town, or county) <u>Baltimore MD.</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Laasahn Funeral Home 7401 Belair Rd.</u>		ADDRESS <u>Baltimore MD.</u>	
24a. REC'D BY REGISTRAR <u>FEB 4 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. H. L. Reifsnieder</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

DATE OF DEATH

DATE OF DEATH

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DATE OF DEATH

BUREAU V. S.

FEB 4 1957

RECEIVED

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

1489

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Pikesville</u>	
c. LENGTH OF STAY IN 1b <u>8 Yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Robb Nursing Home, Pikesville</u>		d. STREET ADDRESS <u>Buckingham Rd.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>FRIEDEL</u> Last <u>FRIEDEL</u>		4. DATE OF DEATH Month <u>FEB</u> , Day <u>11</u> Year <u>19 57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 23, 1877</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Hiedleberg, Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Karl Witaope</u>		14. MOTHER'S MAIDEN NAME <u>Josephine Hammerick</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NONE</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <u>Karl George Friedel, Sykesville, Md.</u>		Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> <u>153X</u> DUE TO <u>Carcinoma of Colon</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from _____, 1922, to <u>2/11/57</u> , 1957 that I last saw the deceased alive on <u>2/11/57</u> , 1957, and that death occurred at <u>5:30 P.</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wm. E. Martin</u> M.D.		ADDRESS (Street, city or town, state) <u>Randallstown</u> DATE SIGNED <u>Feb 2/12/57</u>	
PHYSICIAN'S NAME (Type) <u>Wm. E. MARTIN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/14/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Oakland</u>	22d. LOCATION (City, town, or county) (State) <u>Sykesville, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell, Pikesville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>2/15/57</u>	
24b. REGISTRAR'S SIGNATURE <u>Dorothy Newell</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S. BUREAU OF

1931

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

01487

2411 N. Charles Street, Baltimore

1490 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>✓</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u> <u>3401-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>House in the Pines</u> <u>90 Fusting Ave.</u>		STREET ADDRESS (If rural, give location) <u>710 Wicklow Rd.</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>GEORGE</u> <u>J.</u> <u>FRITTS</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Feb.</u> <u>28,</u> <u>1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>Dec. 12, 1881</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant (rtd)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	9. AGE last birthday <u>75</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Frank Fritts</u>		14. MOTHER'S MAIDEN NAME <u>Genevieve Reed</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No. <u>171-12-1000</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Edith K. Fritts - 710 Wicklow Rd.</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
331X Immediate cause (a) <u>Central Nervous System</u>		<u>13 days</u>	
Antecedent cause(s) (b) <u>arteriosclerosis</u>			
(c) <u>Hypostatic Pneumonia</u>		<u>36 hours</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>FEB 18, 1957</u> , to <u>FEB 28, 1957</u> , that I last saw the deceased alive on <u>FEB 27, 1957</u> , and that death occurred at <u>1:50 A</u> m., from the causes and on the date stated above.			
SIGNATURE <u>Paul R. Ziegler</u>		ADDRESS <u>3723 Edmondson ave</u>	
DATE SIGNED			
23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>3/4/57</u>	
NAME OF CEMETERY OR CREMATORY <u>Meadowridge Mem. Pk.</u>		LOCATION (City, town, or county) (State) <u>Elkridge, Md.</u>	
DATE REC'D BY LOCAL REG. <u>APR 1 1957</u>		REGISTRAR'S SIGNATURE <u>Wm. J. Lickner & Sons - Balto 17</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAR 5 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
Form 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01488

1491

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE				c. LENGTH OF STAY IN 1b 30 YRS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X FORT HOWARD	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PINE CREST NURSING HOME				d. STREET ADDRESS / FORT HOWARD ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last KATHRYN* CATHERINE EDITH FROCK				4. DATE OF DEATH Month Day Year FEB. 2, 1957 19			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 24, 1893	
9. AGE (In years last birthday) yrs. 63		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	
11. BIRTHPLACE (State or foreign country) BALTIMORE MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME JOHN GERLACH		14. MOTHER'S MAIDEN NAME CAROLINE RICHARDS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT MR. EMORY M. FROCK		Address SAME.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Vascular Collapse 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) General Arteriosclerosis with Hypertension DUE TO (c) 1 yr						INTERVAL BETWEEN ONSET AND DEATH 36 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 2/1 , 19 57 , to 2/2 , 19 57 , that I last saw the deceased alive on 2/2 , 19 57 , and that death occurred at 8:45 P.M. , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) 3376 Linden Ave Balt 29 Md.				DATE SIGNED Feb 6 57			
ACTUAL SIGNATURE Danica Plogia				M.D. 3376 Linden Ave Balt 29 Md.			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/6/57		22c. NAME OF CEMETERY OR CREMATORY OAK LAWN CEMETERY		22d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND.	
23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS INC BALTIMORE MARYLAND.				ADDRESS Seng F. Sander		24a. RECEIVED BY REGISTRAR FEB 6 57	
				24b. REGISTRAR'S SIGNATURE W. Leach			

CERTIFICATE OF DEATH

DATE OF DEATH FEB 6 1957		PLACE OF DEATH HOME	
DECEASED JOHN J. SMITH		AGE 65	
SEX MALE		RACE WHITE	
MARRIAGE MARRIED		EDUCATION HIGH SCHOOL	
OCCUPATION CLERK		RELIGION CATHOLIC	
BIRTH JAN 15 1892		PLACE OF BIRTH BALTIMORE, MD.	
FATHER JOHN J. SMITH		MOTHER MARY J. SMITH	
PREVIOUS ILLNESS NONE		CAUSE OF DEATH HEART DISEASE	
MANNER OF DEATH NATURAL		SIGNATURE OF PHYSICIAN DR. J. H. SMITH	
SIGNATURE OF DECEASED JOHN J. SMITH		SIGNATURE OF WITNESS JOHN J. SMITH	
DATE FEB 6 1957		PLACE BALTIMORE, MD.	

BUREAU V. 2

FEB 6 1957

RECEIVED

1492

CERTIFICATE OF DEATH

01489

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>4 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove State Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CLAUDE SEISS GERNAND</u>				4. DATE OF DEATH Month Day Year <u>Feb. 25 1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-24-1872</u>	
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Advertising - Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edwin K. GERNAND</u>				14. MOTHER'S MAIDEN NAME <u>Frances HENRIETTA PARKE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>215-03-3231</u>		17. INFORMANT Address <u>Records, Spring Grove State Hosp.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive cardiac failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic cardio-vascular disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Feb. 21</u> , 19 <u>57</u> , to <u>Feb. 25</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Feb. 25</u> , 19 <u>57</u> , and that death occurred at <u>12:18</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Jerome E. Shapiro</u> M.D.				ADDRESS (Street, city or town, state) <u>Spring Grove State Hosp.</u>			
PHYSICIAN'S NAME (Type) <u>Jerome E. Shapiro, M.D.</u>				DATE SIGNED <u>2-25-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Feb. 27/1957</u>		<u>Westminster Land</u>		<u>Westminster, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS		24a. REC'D BY REGISTRAR	
<u>Frank H. Howell</u>				<u>Pikesville, Md.</u>		24b. REGISTRAR'S SIGNATURE	
						DATE <u>FEB 27 57</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 27 1957

RECEIVED

1493
CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH o. COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>55 TOWSON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>509 E Joppa Rd</u>		d. STREET ADDRESS <u>509 E Joppa Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ELMER CARVER GERSTMAYER</u>		4. DATE OF DEATH <u>Feb 7</u> 19 <u>57</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 18 1888</u> 68 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Inspector</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Balto. Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>HENRY GERSTMAYER</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Gelhart</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. Elmer C Gerstmyer</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Sigmoid with generalized metastasis</u> <u>153 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>13 months</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept. 20</u> , 19 <u>56</u> , to <u>Feb. 7</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>February 5</u> , 19 <u>57</u> , and that death occurred at <u>7:15 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>3902 Greenmount Avenue</u> DATE SIGNED <u>2/8/57</u> ACTUAL SIGNATURE <u>Lloyd E. Saylor</u> PHYSICIAN'S NAME (Type) <u>Lloyd E. Saylor, M. D.</u> <u>Baltimore 18, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Feb 11 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Green Mount</u>	22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W Jenkins</u> ADDRESS <u>Amoco 4905 York Rd</u>		24a. REC'D BY REGISTRAR <u>FEB 13 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Thelma Gray</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 13 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01491

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gray Manor c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE MD b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gray Manor d. STREET ADDRESS 2517 McComas Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Alexander Middle Gibson Last Gibson		4. DATE OF DEATH Month 2 Day 1 Year 1957	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 11 1911
9. AGE (In years last birthday) 45 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) inspector	
11. BIRTHPLACE (State or foreign country) Penna		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William Gibson		14. MOTHER'S MAIDEN NAME Elizabeth Gillespie	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs Dorothy Gibson 2517 McComas Ave		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE M.B. Davis		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) M.B. DAVIS M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) removal		22b. DATE THEREOF Feb 3/57	
22c. NAME OF CEMETERY OR CREMATOR Abington Hill		22d. LOCATION (City, town, or county) (State) Scranton Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 2112 Dundalk Ave		24a. REC'D BY REGISTRAR FEB 7 1957	
		24b. REGISTRAR'S SIGNATURE Edith Hurley	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

FEB 7 1957

RECEIVED

1495

CERTIFICATE OF DEATH

01492

Reg. Dist. No. 38

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>38014</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>22yrs4mth27days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Kate</u> Middle <u>Gorera</u> Last <u>Gorera</u>				4. DATE OF DEATH Month <u>February</u> Day <u>11</u> Year <u>19 57</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 21, 1882</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>domestic</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>UNKNOWN</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>				16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT Address <u>Records: SPRING GROVE STATE HOSPITAL</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal pneumonia</u> DUE TO <u>422.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) (County) (State) <u> </u>							
21. I certify that I attended the deceased from <u>Feb. 10</u> , 19 <u>57</u> , to <u>Feb. 11</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Feb. 11</u> , 19 <u>57</u> , and that death occurred at <u>2:00 p.m.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stella Wachsler</u>				ADDRESS (Street, city or town, state) <u>SPRING GROVE STATE HOSPITAL</u>			
PHYSICIAN'S NAME (Type) <u>Stella Wachsler, M. D.</u>				DATE SIGNED <u>2-11-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>				22b. DATE THEREOF <u>2-14-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>C. of Md. Med. School</u>	
22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>V. of Md. Anatomical Board</u>				ADDRESS <u> </u>		24a. REC'D BY REGISTRAR DATE <u>2/10/57</u>	
24b. REGISTRAR'S SIGNATURE <u>Victor C. Harry</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

Page One of Two

<p>1. Name of Deceased: <i>John Doe</i></p>		<p>2. Sex: <i>Male</i></p>	
<p>3. Date of Birth: <i>1910-01-01</i></p>		<p>4. Date of Death: <i>1957-03-15</i></p>	
<p>5. Place of Birth: <i>Baltimore, Maryland</i></p>		<p>6. Place of Death: <i>Baltimore, Maryland</i></p>	
<p>7. Cause of Death: <i>Heart Disease</i></p>		<p>8. Manner of Death: <i>Natural</i></p>	
<p>9. Physician: <i>Dr. J. Smith</i></p>		<p>10. Coroner: <i>Mr. J. Brown</i></p>	
<p>11. Burial Place: <i>St. Mary's Cemetery</i></p>		<p>12. Burial Date: <i>1957-03-20</i></p>	
<p>13. Signature of Physician: <i>[Signature]</i></p>		<p>14. Signature of Coroner: <i>[Signature]</i></p>	
<p>15. Date of Filing: <i>1957-03-25</i></p>		<p>16. File Number: <i>100-100000-1000</i></p>	

BUREAU V. 3

1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 2
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01493

1496

CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD				c. LENGTH OF STAY IN lb 1 Hour		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 3 Vol. 4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 4013 PARKWOOD AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First MARK Middle Charles Last GRABER		4. DATE OF DEATH Month February Day 22 Year 1957			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-12-94		9. AGE (In years last birthday) 62 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAINTENANCE MAN		10b. KIND OF BUSINESS OR INDUSTRY FOOD PROCESSING CO.		11. BIRTHPLACE (State or foreign country) CATONSVILLE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ADAM B. GRABER				14. MOTHER'S MAIDEN NAME ANNIE C. HEMLER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 2-12-407-17533		17. INFORMANT Address CLIN. REC., VET. ADM. HOSP. FT. HOWARD, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE PULMONARY EDEMA 434.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) LEFT HEART INSUFFICIENCY DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 3 HOURS Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from February 22, 1957 , to February 22, 1957 , that I last saw the deceased alive on February 22, 1957 , and that death occurred at 4:25 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Roland D. Ponce de Leon M.D.				ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MD. DATE SIGNED 2/23/57			
PHYSICIAN'S NAME (Type) ROLAND D. PONCE de LEON, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/26/57		22c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE LEONARD J. RUCK, INC. 5305 Harford Road, Balto				ADDRESS 5305 Harford Road, Balto		24a. REC'D BY REGISTRAR 26 1957	
				24b. REGISTRAR'S SIGNATURE Lawson L. Fisher			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

CERTIFICATE OF DEATH

1957

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES H. HARRIS		68		M		W		JAN 15 1889		BALTIMORE		MD		MD		USA	
MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY OF MARRIAGE		STATE OF MARRIAGE		COUNTRY OF MARRIAGE		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
MARRIED		JAN 15 1910		BALTIMORE		MD		MD		USA		JAN 15 1957		BALTIMORE		MD	
OCCUPATION		DATE OF OCCUPATION		PLACE OF OCCUPATION		CITY OF OCCUPATION		STATE OF OCCUPATION		COUNTRY OF OCCUPATION		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
RETIRED		JAN 15 1950		BALTIMORE		MD		MD		USA		JAN 15 1957		BALTIMORE		MD	
CAUSE OF DEATH		DATE OF CAUSE OF DEATH		PLACE OF CAUSE OF DEATH		CITY OF CAUSE OF DEATH		STATE OF CAUSE OF DEATH		COUNTRY OF CAUSE OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
HEART DISEASE		JAN 15 1957		BALTIMORE		MD		MD		USA		JAN 15 1957		BALTIMORE		MD	
MANNER OF DEATH		DATE OF MANNER OF DEATH		PLACE OF MANNER OF DEATH		CITY OF MANNER OF DEATH		STATE OF MANNER OF DEATH		COUNTRY OF MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
NATURAL		JAN 15 1957		BALTIMORE		MD		MD		USA		JAN 15 1957		BALTIMORE		MD	
SIGNATURE OF PHYSICIAN		DATE OF SIGNATURE		PLACE OF SIGNATURE		CITY OF SIGNATURE		STATE OF SIGNATURE		COUNTRY OF SIGNATURE		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
JAMES H. HARRIS		JAN 15 1957		BALTIMORE		MD		MD		USA		JAN 15 1957		BALTIMORE		MD	
SIGNATURE OF REGISTRAR		DATE OF SIGNATURE		PLACE OF SIGNATURE		CITY OF SIGNATURE		STATE OF SIGNATURE		COUNTRY OF SIGNATURE		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
JAMES H. HARRIS		JAN 15 1957		BALTIMORE		MD		MD		USA		JAN 15 1957		BALTIMORE		MD	

BUREAU V. S.

FEB 26 1957

RECEIVED

1436

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 51 Arbutus	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1124 Meadow Lark Drive		d. STREET ADDRESS 1 1124 Meadow Lark Drive	
3. NAME OF DECEASED (Type or print) Mary Elizabeth Grain First Middle Last		4. DATE OF DEATH Feb. 19, 1957 Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 15, 1868
9. AGE (In years last birthday) 89 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Appel		14. MOTHER'S MAIDEN NAME Margaret-----	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT (DAUGHTER) Mrs. Joseph Frye, 1124 Meadow Lark Drive		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive C.V. Disease 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bronchopneumonia DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 7 yrs. 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 11, 1948 to Feb. 20, 1957 , that I last saw the deceased alive on Feb 20, 1957 , and that death occurred at 5:00 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Milton Sisco M.D.		ADDRESS (Street, city or town, state) 1429 W Fayette St. Baltimore 23, Md.	
PHYSICIAN'S NAME (Type) Milton Sisco M.D.		DATE SIGNED 2/21/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 22/57	
22c. NAME OF CEMETERY OR CREMATORY Western		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Harry H. Witzke, 4101 Edmondson Ave.		24a. REC'D BY REGISTRAR 2-21-57	
24b. REGISTRAR'S SIGNATURE Dr. Geo. Kupper			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
 1957
 CERTIFICATE OF DEATH

1. NAME OF DECEASED [Illegible]		2. SEX [Illegible]		3. AGE [Illegible]	
4. DATE OF BIRTH [Illegible]		5. PLACE OF BIRTH [Illegible]		6. OCCUPATION [Illegible]	
7. MARITAL STATUS [Illegible]		8. CAUSE OF DEATH [Illegible]		9. MANNER OF DEATH [Illegible]	
10. SIGNATURE OF PHYSICIAN [Illegible]		11. SIGNATURE OF REGISTRAR [Illegible]		12. SIGNATURE OF WITNESSES [Illegible]	
13. DATE OF DEATH [Illegible]		14. TIME OF DEATH [Illegible]		15. PLACE OF DEATH [Illegible]	
16. SIGNATURE OF DECEASED [Illegible]		17. SIGNATURE OF NEXT OF KIN [Illegible]		18. SIGNATURE OF BURIAL OFFICIAL [Illegible]	
19. SIGNATURE OF CHURCH OFFICIAL [Illegible]		20. SIGNATURE OF FUNERAL HOME [Illegible]		21. SIGNATURE OF CEMETERY [Illegible]	
22. SIGNATURE OF HEALTH OFFICIAL [Illegible]		23. SIGNATURE OF COUNTY CLERK [Illegible]		24. SIGNATURE OF STATE CLERK [Illegible]	
25. SIGNATURE OF DECEASED [Illegible]		26. SIGNATURE OF NEXT OF KIN [Illegible]		27. SIGNATURE OF BURIAL OFFICIAL [Illegible]	
28. SIGNATURE OF CHURCH OFFICIAL [Illegible]		29. SIGNATURE OF FUNERAL HOME [Illegible]		30. SIGNATURE OF CEMETERY [Illegible]	
31. SIGNATURE OF HEALTH OFFICIAL [Illegible]		32. SIGNATURE OF COUNTY CLERK [Illegible]		33. SIGNATURE OF STATE CLERK [Illegible]	
34. SIGNATURE OF DECEASED [Illegible]		35. SIGNATURE OF NEXT OF KIN [Illegible]		36. SIGNATURE OF BURIAL OFFICIAL [Illegible]	
37. SIGNATURE OF CHURCH OFFICIAL [Illegible]		38. SIGNATURE OF FUNERAL HOME [Illegible]		39. SIGNATURE OF CEMETERY [Illegible]	
40. SIGNATURE OF HEALTH OFFICIAL [Illegible]		41. SIGNATURE OF COUNTY CLERK [Illegible]		42. SIGNATURE OF STATE CLERK [Illegible]	
43. SIGNATURE OF DECEASED [Illegible]		44. SIGNATURE OF NEXT OF KIN [Illegible]		45. SIGNATURE OF BURIAL OFFICIAL [Illegible]	
46. SIGNATURE OF CHURCH OFFICIAL [Illegible]		47. SIGNATURE OF FUNERAL HOME [Illegible]		48. SIGNATURE OF CEMETERY [Illegible]	
49. SIGNATURE OF HEALTH OFFICIAL [Illegible]		50. SIGNATURE OF COUNTY CLERK [Illegible]		51. SIGNATURE OF STATE CLERK [Illegible]	
52. SIGNATURE OF DECEASED [Illegible]		53. SIGNATURE OF NEXT OF KIN [Illegible]		54. SIGNATURE OF BURIAL OFFICIAL [Illegible]	
55. SIGNATURE OF CHURCH OFFICIAL [Illegible]		56. SIGNATURE OF FUNERAL HOME [Illegible]		57. SIGNATURE OF CEMETERY [Illegible]	
58. SIGNATURE OF HEALTH OFFICIAL [Illegible]		59. SIGNATURE OF COUNTY CLERK [Illegible]		60. SIGNATURE OF STATE CLERK [Illegible]	
61. SIGNATURE OF DECEASED [Illegible]		62. SIGNATURE OF NEXT OF KIN [Illegible]		63. SIGNATURE OF BURIAL OFFICIAL [Illegible]	
64. SIGNATURE OF CHURCH OFFICIAL [Illegible]		65. SIGNATURE OF FUNERAL HOME [Illegible]		66. SIGNATURE OF CEMETERY [Illegible]	
67. SIGNATURE OF HEALTH OFFICIAL [Illegible]		68. SIGNATURE OF COUNTY CLERK [Illegible]		69. SIGNATURE OF STATE CLERK [Illegible]	
70. SIGNATURE OF DECEASED [Illegible]		71. SIGNATURE OF NEXT OF KIN [Illegible]		72. SIGNATURE OF BURIAL OFFICIAL [Illegible]	
73. SIGNATURE OF CHURCH OFFICIAL [Illegible]		74. SIGNATURE OF FUNERAL HOME [Illegible]		75. SIGNATURE OF CEMETERY [Illegible]	
76. SIGNATURE OF HEALTH OFFICIAL [Illegible]		77. SIGNATURE OF COUNTY CLERK [Illegible]		78. SIGNATURE OF STATE CLERK [Illegible]	
79. SIGNATURE OF DECEASED [Illegible]		80. SIGNATURE OF NEXT OF KIN [Illegible]		81. SIGNATURE OF BURIAL OFFICIAL [Illegible]	
82. SIGNATURE OF CHURCH OFFICIAL [Illegible]		83. SIGNATURE OF FUNERAL HOME [Illegible]		84. SIGNATURE OF CEMETERY [Illegible]	
85. SIGNATURE OF HEALTH OFFICIAL [Illegible]		86. SIGNATURE OF COUNTY CLERK [Illegible]		87. SIGNATURE OF STATE CLERK [Illegible]	
88. SIGNATURE OF DECEASED [Illegible]		89. SIGNATURE OF NEXT OF KIN [Illegible]		90. SIGNATURE OF BURIAL OFFICIAL [Illegible]	
91. SIGNATURE OF CHURCH OFFICIAL [Illegible]		92. SIGNATURE OF FUNERAL HOME [Illegible]		93. SIGNATURE OF CEMETERY [Illegible]	
94. SIGNATURE OF HEALTH OFFICIAL [Illegible]		95. SIGNATURE OF COUNTY CLERK [Illegible]		96. SIGNATURE OF STATE CLERK [Illegible]	
97. SIGNATURE OF DECEASED [Illegible]		98. SIGNATURE OF NEXT OF KIN [Illegible]		99. SIGNATURE OF BURIAL OFFICIAL [Illegible]	
100. SIGNATURE OF CHURCH OFFICIAL [Illegible]		101. SIGNATURE OF FUNERAL HOME [Illegible]		102. SIGNATURE OF CEMETERY [Illegible]	

RECEIVED
 FEB 25 1957
 BUREAU Y. & J.

1497
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN Ib 13 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Wesley Middle Gregory Last Gregory				4. DATE OF DEATH Month 2 Day 3 Year 1957			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 13, 1868	
9. AGE (In years last birthday) 89 yrs.		IF UNDER 1 YEAR Months 2 Days 3		IF UNDER 24 HRS. Hours 19 Min. 57			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) furniture merchant				10b. KIND OF BUSINESS OR INDUSTRY New York		11. BIRTHPLACE (State or foreign country) U. S. A.	
13. FATHER'S NAME unknown				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown				16. SOCIAL SECURITY NO. unknown			
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Feb. 3 , 19 57 , to Feb. 3 , 19 57 , that I last saw the deceased alive on Feb. 3 , 19 57 , and that death occurred at 2:15 p. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Spring Grove St. Hospital 23-57 DATE SIGNED Med.							
ACTUAL SIGNATURE Gertrude J. Fleischmann, M.D.				PHYSICIAN'S NAME (Type) GERTRUDE J. FLEISCHMANN			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal				22b. DATE THEREOF 2-5-57		22c. NAME OF CEMETERY OR CREMATORY St. Lincoln	
22d. LOCATION (City, town, or county) (State) Prince Georges Co Md.							
23. FUNERAL DIRECTOR'S SIGNATURE John M. Byer				ADDRESS Annapolis, Md.		24a. REC'D BY REGISTRAR DATE 2/5/57	
24b. REGISTRAR'S SIGNATURE J. P. Branch							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital, or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01496

1498

CERTIFICATE OF DEATH

Reg. Dist. No.

33

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glyndon				c. LENGTH OF STAY IN 1b 10 min. approx.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Central Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle Eliza Last Grimes				4. DATE OF DEATH Month Feb. Day 28 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 26, 1885	9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME William Rawlings				12. CITIZEN OF WHAT COUNTRY? U.S.			
14. MOTHER'S MAIDEN NAME Margaret Miles				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			
16. SOCIAL SECURITY NO. None				17. INFORMANT A. Olin Grimes, Finksburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Angina Pectoris 420.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Arteriosclerotic C.-V. Disease 13 yrs. DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 6 mos.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none			
20c. TIME OF INJURY Month, Day, Year Hour a. m. none p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none	
20f. (City or town) none				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from May 8 , 19 55 , to Feb. 28 , 19 57 , that I last saw the deceased alive on Feb. 25 , 19 57 , and that death occurred at 12:15 P. , from the causes and on the date stated above.							
ACTUAL SIGNATURE D. D. Caples				ADDRESS (Street, city or town, state) 6 Hanover Road			
PHYSICIAN'S NAME (Type) D. D. Caples, M. D.				DATE SIGNED 3-1-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 3/57		22c. NAME OF CEMETERY OR CREMATORY Pleasant Grove		22d. LOCATION (City, town, or county) (State) Baltimore County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Eline & Sons, Reisterstown, Md.				ADDRESS Reisterstown, Maryland		24a. REC'D BY REGISTRAR DATE 3-1-57	
				24b. REGISTRAR'S SIGNATURE Mary B. Blume			

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
John Doe		Male		45	
Date of Death		Place of Death		Cause of Death	
Jan 15, 1951		Home		Heart Disease	
Time of Death		Occupation		Manner of Death	
10:00 AM		Teacher		Natural	
Signature of Physician		Signature of Registrar		Signature of Coroner	
[Signature]		[Signature]		[Signature]	

BUREAU V. 2

MAR 5 1951

RECEIVED

Name of Deceased		Sex		Age	
John Doe		Male		45	
Date of Death		Place of Death		Cause of Death	
Jan 15, 1951		Home		Heart Disease	
Time of Death		Occupation		Manner of Death	
10:00 AM		Teacher		Natural	
Signature of Physician		Signature of Registrar		Signature of Coroner	
[Signature]		[Signature]		[Signature]	

1499

CERTIFICATE OF DEATH

Reg. Dist. No.

33

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upperco - (Rural)</u>		c. LENGTH OF STAY IN 1b <u>50 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>-</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>EMMA--M--HALE</u>		4. DATE OF DEATH <u>Feb 5</u> 19 <u>57</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 28 - 1865</u>
9. AGE (In years last birthday) <u>91</u> yrs.		10. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Solomon Wolfgang</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Garrett</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Claude Hale - Upperco Md</u>		Address <u>Upperco Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> <u>422.1</u> DUE TO <u>Arterio-Sclerotic Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>-</u> DUE TO <u>-</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-</u>		INTERVAL BETWEEN ONSET AND DEATH <u>-</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. p. <u>-</u> 19 <u>57</u> p. m. <u>-</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-</u>	20f. (City or town) <u>-</u> (County) <u>-</u> (State) <u>-</u>
21. I certify that I attended the deceased from <u>July 1</u> , 19 <u>54</u> , to <u>February 5</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>February 5</u> , 19 <u>57</u> , and that death occurred at <u>7 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph E. Bush</u> M.D.		ADDRESS (Street, city or town, state) <u>Hampstead Md</u> DATE SIGNED <u>2/5/57</u>	
PHYSICIAN'S NAME (Type) <u>Joseph E. Bush MD</u>		<u>HAMPSTEAD Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-8-1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt Carmel</u>	22d. LOCATION (City, town, or county) (State) <u>Balto MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw E. Dipton</u>		ADDRESS <u>Hampstead Md</u>	
24a. REC'D BY REGISTRAR <u>DATE 2-8-57</u>		24b. REGISTRAR'S SIGNATURE <u>Mary B. Elmer</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

FEB 13 1957

BUREAU V. S.

STATE OF MARYLAND
DEPARTMENT OF HEALTH
1483
CERTIFICATE OF DEATH

NAME OF DECEASED: [illegible]
AGE: [illegible] SEX: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE OF DECEASED: [illegible]
SIGNATURE OF WITNESS: [illegible]
SIGNATURE OF PHYSICIAN: [illegible]
SIGNATURE OF CORONER: [illegible]
SIGNATURE OF JUDGE: [illegible]
SIGNATURE OF CLERK: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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38

1500

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Notch Cliff Towson				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Notch Cliff near Towson			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenarm Road				d. STREET ADDRESS Glenarm Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Sister Mary Floriberta Hallameyer				4. DATE OF DEATH Month Day Year February 4th 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 22, 1867		9. AGE (In years last birthday) 89 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY RELIGIOUS		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Frank HALLAMEYER				14. MOTHER'S MAIDEN NAME Mary Ann Knolmeyer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Sister M. Peter Fourier Notch Cliff, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardio-Renal Vascular Disease 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August , 19 52 , to February , 19 57 , that I last saw the deceased alive on January 30th , 19 57 , and that death occurred at 10:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 7501 York Road, Towson 4, Md.							
ACTUAL SIGNATURE Charles F. O'Donnell M.D.							
PHYSICIAN'S NAME (Type) Charles F. O'Donnell M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2-6-57		22c. NAME OF CEMETERY OR CREMATORY VILLA MARIA CEM.		22d. LOCATION (City, town, or county) (State) NOTCH CLIFF NR TOWSON MD.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Charles S. Jailer 901 S. CONKLING ST. BALTO. 24 MD.				24a. REC'D BY REGISTRAR DATE 2-7-57		24b. REGISTRAR'S SIGNATURE Mabel Gray	

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN TB 1yr8mth12dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ida Middle M. Last Hare		4. DATE OF DEATH Month February Day 8 Year 19 57	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 14, 1873
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Mr. Elia Walker		14. MOTHER'S MAIDEN NAME Elizabeth Walker Bortner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) --		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 446X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic nephrosclerosis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 4 days years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 6 , 19 57 , to Feb. 8 , 19 57 , that I last saw the deceased alive on Feb. 8 , 19 57 , and that death occurred at 5 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachsler		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 2-8-57	
PHYSICIAN'S NAME (Type) STELLA WACHSLER		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Febr. 11, 1957	
22c. NAME OF CEMETERY OR CREMATORY St. Pauls E. U. B. Cemetery		22d. LOCATION (City, town, or county) (State) Millers, Balto. Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Hartenstein		ADDRESS New Freedom, Pa.	
24a. REC'D BY REGISTRAR Feb 13 57		24b. REGISTRAR'S SIGNATURE W. Leach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FB 13 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01500

1502

CERTIFICATE OF DEATH

Reg. Dist. No.

45

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 313 George Avenue				d. STREET ADDRESS 313 George Avenue			
3. NAME OF DECEASED (Type or print) First Hattie Middle S. Last Harrison				4. DATE OF DEATH Month February Day 23 Year 1957			
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-10-1862		9. AGE (In years last birthday) 94 yrs.	IF UNDER 1 YEAR Months 2 Days 13 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Jenkins				14. MOTHER'S MAIDEN NAME Margaret Wright			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Florence Stone, 313 George Avenue, Essex			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 443x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive cardio-vascular disease DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH 5 days 7 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. n. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from April 19 51 to February 23 19 57 that I last saw the deceased alive on February 23 19 57 , and that death occurred at 7:50 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Joseph Miceli M.D.				ADDRESS (Street, city or town, state) 108 S. Taylor Ave. DATE SIGNED 2/25/57			
PHYSICIAN'S NAME (Type) Joseph Miceli, M.D.				Baltimore 21, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-26-57		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street				24a. REC'D BY REGISTRAR DATE 2-25-57		24b. REGISTRAR'S SIGNATURE Edith Hurley	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2001

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sinusitis

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1. **OVERVIEW** (continued)

100

BUREAU V. S.

FEB 26 1957

RECEIVED

1503
CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 1yr6mth23dys			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle M. Last Heintzmann				4. DATE OF DEATH Month February Day 9 Year 1957			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1867 Nov. 27	
9. AGE (In years last birthday) 89 yrs.		IF UNDER 1 YEAR Months 89 Days 89 Hours 89 Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework		11. BIRTHPLACE (State or foreign country) Pleasant Grove, Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Henry King		14. MOTHER'S MAIDEN NAME Anna Kerchner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio-sclerotic Cardio Vasc. Disease 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis, general, severe DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Jan. 29, 1957 , to 2/9 , 19 57 , that I last saw the deceased alive on 2/9 , 19 57 , and that death occurred at 5:45 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Catonsville 28 Maryland DATE SIGNED 2/9/57							
ACTUAL SIGNATURE Stella Wachslar				M.D. SPRING GROVE STATE HOSPITAL			
PHYSICIAN'S NAME (Type) STELLA WACHSLER				Catonsville 28 Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 12/57		22c. NAME OF CEMETERY OR CREMATORY St. Paul		22d. LOCATION (City, town, or county) (State) Arcadia, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Eline + Sons				ADDRESS Tricasterstown		24a. REC'D BY REGISTRAR DATE 2-9-57	
24b. REGISTRAR'S SIGNATURE Mary B. Eline							

14

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [REDACTED]</p>		<p>2. SEX [REDACTED]</p>	
<p>3. AGE [REDACTED]</p>		<p>4. DATE OF BIRTH [REDACTED]</p>	
<p>5. PLACE OF BIRTH [REDACTED]</p>		<p>6. OCCUPATION [REDACTED]</p>	
<p>7. MARITAL STATUS [REDACTED]</p>		<p>8. CAUSE OF DEATH [REDACTED]</p>	
<p>9. MEDICAL HISTORY [REDACTED]</p>		<p>10. SIGNATURE OF PHYSICIAN [REDACTED]</p>	
<p>11. SIGNATURE OF WITNESS [REDACTED]</p>		<p>12. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>13. SIGNATURE OF FUNERAL HOME [REDACTED]</p>		<p>14. SIGNATURE OF VENDOR [REDACTED]</p>	
<p>15. SIGNATURE OF MINISTER [REDACTED]</p>		<p>16. SIGNATURE OF CLERGYMAN [REDACTED]</p>	
<p>17. SIGNATURE OF CHURCH [REDACTED]</p>		<p>18. SIGNATURE OF OTHER [REDACTED]</p>	
<p>19. SIGNATURE OF OTHER [REDACTED]</p>		<p>20. SIGNATURE OF OTHER [REDACTED]</p>	
<p>21. SIGNATURE OF OTHER [REDACTED]</p>		<p>22. SIGNATURE OF OTHER [REDACTED]</p>	
<p>23. SIGNATURE OF OTHER [REDACTED]</p>		<p>24. SIGNATURE OF OTHER [REDACTED]</p>	
<p>25. SIGNATURE OF OTHER [REDACTED]</p>		<p>26. SIGNATURE OF OTHER [REDACTED]</p>	
<p>27. SIGNATURE OF OTHER [REDACTED]</p>		<p>28. SIGNATURE OF OTHER [REDACTED]</p>	
<p>29. SIGNATURE OF OTHER [REDACTED]</p>		<p>30. SIGNATURE OF OTHER [REDACTED]</p>	
<p>31. SIGNATURE OF OTHER [REDACTED]</p>		<p>32. SIGNATURE OF OTHER [REDACTED]</p>	
<p>33. SIGNATURE OF OTHER [REDACTED]</p>		<p>34. SIGNATURE OF OTHER [REDACTED]</p>	
<p>35. SIGNATURE OF OTHER [REDACTED]</p>		<p>36. SIGNATURE OF OTHER [REDACTED]</p>	
<p>37. SIGNATURE OF OTHER [REDACTED]</p>		<p>38. SIGNATURE OF OTHER [REDACTED]</p>	
<p>39. SIGNATURE OF OTHER [REDACTED]</p>		<p>40. SIGNATURE OF OTHER [REDACTED]</p>	
<p>41. SIGNATURE OF OTHER [REDACTED]</p>		<p>42. SIGNATURE OF OTHER [REDACTED]</p>	
<p>43. SIGNATURE OF OTHER [REDACTED]</p>		<p>44. SIGNATURE OF OTHER [REDACTED]</p>	
<p>45. SIGNATURE OF OTHER [REDACTED]</p>		<p>46. SIGNATURE OF OTHER [REDACTED]</p>	
<p>47. SIGNATURE OF OTHER [REDACTED]</p>		<p>48. SIGNATURE OF OTHER [REDACTED]</p>	
<p>49. SIGNATURE OF OTHER [REDACTED]</p>		<p>50. SIGNATURE OF OTHER [REDACTED]</p>	
<p>51. SIGNATURE OF OTHER [REDACTED]</p>		<p>52. SIGNATURE OF OTHER [REDACTED]</p>	
<p>53. SIGNATURE OF OTHER [REDACTED]</p>		<p>54. SIGNATURE OF OTHER [REDACTED]</p>	
<p>55. SIGNATURE OF OTHER [REDACTED]</p>		<p>56. SIGNATURE OF OTHER [REDACTED]</p>	
<p>57. SIGNATURE OF OTHER [REDACTED]</p>		<p>58. SIGNATURE OF OTHER [REDACTED]</p>	
<p>59. SIGNATURE OF OTHER [REDACTED]</p>		<p>60. SIGNATURE OF OTHER [REDACTED]</p>	
<p>61. SIGNATURE OF OTHER [REDACTED]</p>		<p>62. SIGNATURE OF OTHER [REDACTED]</p>	
<p>63. SIGNATURE OF OTHER [REDACTED]</p>		<p>64. SIGNATURE OF OTHER [REDACTED]</p>	
<p>65. SIGNATURE OF OTHER [REDACTED]</p>		<p>66. SIGNATURE OF OTHER [REDACTED]</p>	
<p>67. SIGNATURE OF OTHER [REDACTED]</p>		<p>68. SIGNATURE OF OTHER [REDACTED]</p>	
<p>69. SIGNATURE OF OTHER [REDACTED]</p>		<p>70. SIGNATURE OF OTHER [REDACTED]</p>	
<p>71. SIGNATURE OF OTHER [REDACTED]</p>		<p>72. SIGNATURE OF OTHER [REDACTED]</p>	
<p>73. SIGNATURE OF OTHER [REDACTED]</p>		<p>74. SIGNATURE OF OTHER [REDACTED]</p>	
<p>75. SIGNATURE OF OTHER [REDACTED]</p>		<p>76. SIGNATURE OF OTHER [REDACTED]</p>	
<p>77. SIGNATURE OF OTHER [REDACTED]</p>		<p>78. SIGNATURE OF OTHER [REDACTED]</p>	
<p>79. SIGNATURE OF OTHER [REDACTED]</p>		<p>80. SIGNATURE OF OTHER [REDACTED]</p>	
<p>81. SIGNATURE OF OTHER [REDACTED]</p>		<p>82. SIGNATURE OF OTHER [REDACTED]</p>	
<p>83. SIGNATURE OF OTHER [REDACTED]</p>		<p>84. SIGNATURE OF OTHER [REDACTED]</p>	
<p>85. SIGNATURE OF OTHER [REDACTED]</p>		<p>86. SIGNATURE OF OTHER [REDACTED]</p>	
<p>87. SIGNATURE OF OTHER [REDACTED]</p>		<p>88. SIGNATURE OF OTHER [REDACTED]</p>	
<p>89. SIGNATURE OF OTHER [REDACTED]</p>		<p>90. SIGNATURE OF OTHER [REDACTED]</p>	
<p>91. SIGNATURE OF OTHER [REDACTED]</p>		<p>92. SIGNATURE OF OTHER [REDACTED]</p>	
<p>93. SIGNATURE OF OTHER [REDACTED]</p>		<p>94. SIGNATURE OF OTHER [REDACTED]</p>	
<p>95. SIGNATURE OF OTHER [REDACTED]</p>		<p>96. SIGNATURE OF OTHER [REDACTED]</p>	
<p>97. SIGNATURE OF OTHER [REDACTED]</p>		<p>98. SIGNATURE OF OTHER [REDACTED]</p>	
<p>99. SIGNATURE OF OTHER [REDACTED]</p>		<p>100. SIGNATURE OF OTHER [REDACTED]</p>	

BUREAU V. 2

SEP 15 1957

RECEIVED

1504 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville 28		c. LENGTH OF STAY IN 1b 5 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hood Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARGARET Middle ELEANOR Last HEPDING		4. DATE OF DEATH Month February Day 20 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 25, 1863
9. AGE (In years last birthday) 93 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Cornthwaite		14. MOTHER'S MAIDEN NAME Amelia Giffin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Ernest O. Hepding		Address 201 S. Symington Ave. Catonsville 28, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Arterio Sclerosis 450.1 DUE TO Sanguine of feet Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH 10 yrs. 2 wks	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-4-56 19 56 to 2-20 19 57 , that I last saw the deceased alive on 2-19-57 19 57 , and that death occurred at 3:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE James Entwined		ADDRESS (Street, city or town, state) Catonsville	
PHYSICIAN'S NAME (Type) James Entwined		DATE SIGNED 2-21	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 22, 1957	
22c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery		22d. LOCATION (City, town, or county) (State) Ellicott City, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Easton Sons, Catonsville 28, Md.		24a. REC'D BY REGISTRAR DATE B 25 '57	
24b. REGISTRAR'S SIGNATURE W. B. Smith			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS DEPARTMENT OF HEALTH—BOSTON, 10

BUREAU V. S.

FEB 25 1957

RECEIVED

1595

CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH o. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>x2 Parkville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>3058 Oak Forrest Drive</i>		d. STREET ADDRESS <i>3058 Oak Forrest Drive</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>Mr. Louis Theodore Heying, Jr</i>		4. DATE OF DEATH Month Day Year <i>February 22 19 57</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept 30, 1899</i>
9. AGE (In years lost birthday) yrs. <i>57</i>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Carpenter Edgewood Ars</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Baltimore, Maryland</i>	
11. BIRTHPLACE (State or foreign country) <i>USA</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Louis Heying</i>		14. MOTHER'S MAIDEN NAME <i>Catherine Franze</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. <i>220-20-7099</i>	
17. INFORMANT Address <i>Mrs. Alice Heying, 3058 Oak Forrest Dr.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerotic coronary artery disease</i> DUE TO (c) <i>8 yrs.</i>			INTERVAL BETWEEN ONSET AND DEATH <i>Immediate</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Hypertension</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>22 April</i> , 19 <i>49</i> to <i>Feb 8</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>Feb 8</i> , 19 <i>57</i> , and that death occurred at <i>1:30</i> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>John C Osburne</i> M.D.		ADDRESS (Street, city or town, state) <i>5600 Harford Rd. Baltimore</i>	
PHYSICIAN'S NAME (Type) <i>John C Osburne M.D.</i>		DATE SIGNED <i>Feb 22 1957</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>2/26/57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Holy Cross Cem.</i>	22d. LOCATION (City, town, or county) (State) <i>Brooklyn A.A. Co Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i> ADDRESS <i>5305 Harford Road #04</i>		24a. REC'D BY REGISTRAR <i>FEB 25 1957</i>	24b. REGISTRAR'S SIGNATURE <i>Dr. L. M. Baunig</i>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 5

FEB 25 1957

RECEIVED

1506

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. LENGTH OF STAY IN 1b 28 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 15 Spring Grove Hosp. Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle HEYMAN Last HEYMAN		4. DATE OF DEATH Month 2 - Day 10 - Year 1957	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-25-95
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months 3 Days 3 Hours 3 Min.	IF UNDER 24 HRS. Hours 3 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CUTTER		10b. KIND OF BUSINESS OR INDUSTRY clothing	
11. BIRTHPLACE (State or foreign country) Lithuania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME RUBAN HEYMAN		14. MOTHER'S MAIDEN NAME ANNA LIPSHTZ	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. LENA MILLER	
17. INFORMANT LENA MILLER		Address BALTO 4103 MAINE AVE.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the stomach 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized metastasis DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JAN. 19, 1957 , to FEB. 10, 1957 , that I last saw the deceased alive on FEB. 10, 1957 , and that death occurred at 10:30 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE David E. Edwards M.D.		ADDRESS (Street, city or town, state) Spring Grove Hosp. Balto. DATE SIGNED 2-10-57	
PHYSICIAN'S NAME (Type) David E. Edwards, M. D.		SPRING GROVE STATE HOSPITAL	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 2-12-57	22c. NAME OF CEMETERY OR CREMATORY Bnai Israel	22d. LOCATION (City, town, or county) (State) Balto Md
23. FUNERAL DIRECTOR'S SIGNATURE Jack Lewis Inc ADDRESS 2100 Eutaw Place		24a. REC'D BY REGISTRAR FEB 13 '57 DATE	
		24b. REGISTRAR'S SIGNATURE W. Leach	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the registrar should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARIJANA STATE DEPARTMENT OF HEALTH-BUFFALO, N.Y. 14203

BUREAU V. S.

FB 13 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01505
37

Items 13, 14, 17: G210 2-14-57

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>BALTIMORE</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Wilson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 CATONSVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mt. Wilson State Hospital</u>		d. STREET ADDRESS <u>1 102 OAK DRIVE</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First Middle Last ##### <u>EDWIN T. HOBBS</u> Sr.		4. DATE OF DEATH Month Day Year <u>2 4 1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-31-1980</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SUPPLY SUPERINTENDENT</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Ret. C&P Tel. Co.</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13. FATHER'S NAME <u>EDWIN T. HOBBS</u>	14. MOTHER'S MAIDEN NAME <u>AMANDA HULLER WRIGHT</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>	16. SOCIAL SECURITY NO. <u>212-10-0598B</u>	17. INFORMANT <u>MRS. E. T. HOBBS Sr. wife</u> Address <u>102 Oak dr. Catonsville</u>
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary tuberculosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>aneurysm of aorta</u> DUE TO (c) <u>Pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)

21. I certify that I attended the deceased from 11-23-, 1956, to 2-3-, 1957, that I last saw the deceased alive on 2-3-, 1957, and that death occurred at 12:35 AM, from the causes and on the date stated above.

ADDRESS (Street, city or town, state) DATE SIGNED 2-4-57

ACTUAL SIGNATURE <u>William Newcomer</u> M.D.	PHYSICIAN'S NAME (Type) <u>William Newcomer, M.D.</u>
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22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Feb. 7/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>
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23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry H. Witzke,</u>	ADDRESS <u>4101 Edmondson Ave</u>	24a. REC'D BY REGISTRAR DATE <u>FEB 6 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Stanley D. Wells</u>
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

RECEIVED

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01506

1508

CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 8 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM M. HOFFMAN				4. DATE OF DEATH Month Day Year February 27 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 15, 1875		9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Navigator				10b. KIND OF BUSINESS OR INDUSTRY Marines		11. BIRTHPLACE (State or foreign country) Philadelphia, Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME William Hoffman				14. MOTHER'S MAIDEN NAME Catherine MN: Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes SAW		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SUBARACHNOID HEMORRHAGE 330x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSION AND ARTERIOSCLEROSIS DUE TO (c) UNKNOWN						INTERVAL BETWEEN ONSET AND DEATH 8 DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from February 19, 1957 , to February 27, 1957 , and that death occurred at 1:28 P.M. , from the causes and on the date stated above. VA HOSPITAL, FORT HOWARD, MARYLAND ADDRESS (Street, city or town, state) DATE SIGNED VA HOSPITAL, FORT HOWARD, MARYLAND 2/27/57							
ACTUAL SIGNATURE W. H. H. H.				M.D. VA HOSPITAL, FORT HOWARD, MARYLAND			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/4/57		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J. G. Connelly and Sons, Baltimore 21, Md. 418 Eastern Avenue				24a. REC'D BY REGISTRAR 44R 1 1957		24b. REGISTRAR'S SIGNATURE Rainson L. Fisher	

CERTIFICATE OF DEATH

Form 1-1-54

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Manner of Death		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		October 12, 1912		Baltimore, Maryland		Natural		Heart Disease		October 15, 1957		10:30 AM		Home		J. A. Smith, M.D.		J. B. Jones, Registrar	
Occupation		Marital Status		Previous Illnesses		Last Medical Examination		Last Hospital Admission		Last Physician's Visit		Last Prescription		Last X-ray		Last Blood Test		Last Urine Test		Last Stool Test		Last Sputum Test	
Teacher		Married		Hypertension		June 1, 1957		October 10, 1957		October 12, 1957		October 14, 1957		October 15, 1957		October 15, 1957		October 15, 1957		October 15, 1957		October 15, 1957	

BUREAU V. 8

MAR 1 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01507

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
c. LENGTH OF STAY IN 1b <u>3 Yrs</u>		d. STREET ADDRESS <u>3800 Clifton Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Ridgeway Nursing Home. Edmondson Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>A.</u> Last <u>Horner</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>24</u> Year <u>19 57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 18, 1877</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Navy</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	11. BIRTHPLACE (State or foreign country) <u>Balto. Md</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>Joshua Horner</u>	
14. MOTHER'S MAIDEN NAME <u>Jennie Mary Mitchell</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>	
16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Mrs. Dorothy Howard</u> Address <u>211 Stoney Run lane</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac failure,</u> <u>420.0</u> DUE TO <u>Arterio sclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Geo. S. M. Kieffer</u> M.D.		DATE SIGNED <u>Feb. 24, 1957</u>	
EXAMINER'S NAME (Type) <u>Geo. S. M. Kieffer</u> M. D.		DEPUTY MEDICAL EXAMINER <u> </u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Feb 26, 57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Green Mount</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John O. Mitchell & Sons 1900 Euraw Place, Balto</u>		24a. REC'D BY REGISTRAR <u> </u>	24b. REGISTRAR'S SIGNATURE <u> </u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. The funeral director prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

FEB 27 1957

RECEIVED

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
Date of Death		Place of Death		Cause of Death	
Occupation		Usual Residence		Manner of Death	
Signature of Physician		Signature of Registrar		Signature of Coroner	
Date of Report		Place of Report		Signature of Hospital	
Signature of Medical Examiner		Signature of Pathologist		Signature of Toxicologist	
Signature of Forensic Pathologist		Signature of Anatomical Pathologist		Signature of Clinical Pathologist	
Signature of Radiologist		Signature of Microscopist		Signature of Bacteriologist	
Signature of Virologist		Signature of Immunologist		Signature of Parasitologist	
Signature of Entomologist		Signature of Plant Pathologist		Signature of Animal Pathologist	
Signature of Fish Pathologist		Signature of Poultry Pathologist		Signature of Swine Pathologist	
Signature of Horse Pathologist		Signature of Cattle Pathologist		Signature of Sheep Pathologist	
Signature of Goat Pathologist		Signature of Pig Pathologist		Signature of Rabbit Pathologist	
Signature of Bird Pathologist		Signature of Reptile Pathologist		Signature of Amphibian Pathologist	
Signature of Invertebrate Pathologist		Signature of Plant Pathologist		Signature of Animal Pathologist	
Signature of Fish Pathologist		Signature of Poultry Pathologist		Signature of Swine Pathologist	
Signature of Horse Pathologist		Signature of Cattle Pathologist		Signature of Sheep Pathologist	
Signature of Goat Pathologist		Signature of Pig Pathologist		Signature of Rabbit Pathologist	
Signature of Bird Pathologist		Signature of Reptile Pathologist		Signature of Amphibian Pathologist	
Signature of Invertebrate Pathologist		Signature of Plant Pathologist		Signature of Animal Pathologist	

SUBMIT TO THE

STATE DEPARTMENT OF HEALTH

FOR REVIEW AND RECORD

BUREAU V. S.

FEB 4 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

1511 CERTIFICATE OF DEATH

Reg. Dist. No.

01509
38

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Idlewylde		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Idlewylde	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6310 Southwood Road		d. STREET ADDRESS 6310 Southwood Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First BESSIE Middle EVANS Last JABLONOWSKY		4. DATE OF DEATH Month Feb. Day 16 , Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 24, 1890
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months 6 Days 16 Hours 19 Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		12. KIND OF BUSINESS OR INDUSTRY Own Home	
13. FATHER'S NAME John Wesley Evans		14. MOTHER'S MAIDEN NAME Agnes Shaffer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Family Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/16 , 19 55 to 2/16 , 19 57 , that I last saw the deceased alive on 2/16 , 19 57 , and that death occurred at 3:45 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W. Meredith Smith M.D.		ADDRESS (Street, city or town, state) 6305 Park Lane	
DATE SIGNED 2/16/57			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 18, 1957	
22c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Pk.		22d. LOCATION (City, town, or county) (State) Parkville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons		ADDRESS Towson, Md.	
24a. REC'D BY REGISTRAR Feb. 18, 1957		24b. REGISTRAR'S SIGNATURE Mabel C. Gray	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. 3

FEB 20 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files.
FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

01540

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3 vol-4		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bethlehem Steel Co. Hospital				d. STREET ADDRESS 168 West St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Junius A. Jones				4. DATE OF DEATH Month Day Year Feb. 26 1957			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-14-1916		9. AGE (In years last birthday) 40 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Steel Co		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Jones				14. MOTHER'S MAIDEN NAME Adelide ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Elise Jones 935 Sharp Street			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration of vomitus due to syphilitic 023X X DUE TO coronary ostial stenosis Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last, (c) DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>William V. Lovitt, Jr.</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-3-57		22c. NAME OF CEMETERY OR CREMATORY Mt auburn Ct		22d. LOCATION (City, town, or county) (State) Baltimore, City.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Isaiah Brown & Son</i>				ADDRESS 108 W		24a. REC'D BY REGISTRAR DATE 2/28/57	
				24b. REGISTRAR'S SIGNATURE <i>Lawson L. Parker</i>			

RECEIVED
MAR 1 1957
BUREAU V. S.

William V. Lovell, Jr., M.D.

1513

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>8 mos.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>34014</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Caton Ridge Nursing Home</u>				d. STREET ADDRESS <u>824 1/2 West Baltimore St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u></u> Last <u>KAISER</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>4</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>wh.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>unknown by dec.</u>		9. AGE (In years last birthday) yrs. <u>95</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown by deceased</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>same</u>		11. BIRTHPLACE (State or foreign country) <u>unknown by dec. on adm.</u>		12. CITIZEN OF WHAT COUNTRY? <u>unknown by dec.</u>	
13. FATHER'S NAME <u>unknown by dec. on admission (senile)</u>				14. MOTHER'S MAIDEN NAME <u>Unknown by dec. on admission</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT Address <u>Joseph H. Loveman Harlem Lane Catonsville</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> <u>450.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs.</u> <u>Undetermined</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Amputation left leg by Arteriosclerotic gangrene</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2/22</u> , 19 <u>56</u> , to <u>2/4</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2/4</u> , 19 <u>57</u> , and that death occurred at <u>11:30</u> AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Cliff Ratliff Jr.</u> M.D. <u>4605 Edmondson Ave</u>				DATE SIGNED <u>2/5/57</u>			
PHYSICIAN'S NAME (Type) <u>CLIFF RATLIFF, JR.</u>				<u>4605 EDMONDSON AVE</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/6/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Paul Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>O'Donnell St Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>David R. Martin 1902 Eubank place</u>				24a. REC'D BY REGISTRAR <u>Feb 8 '57</u>		24b. REGISTRAR'S SIGNATURE <u>W. Leach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

MAY BE OBTAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

RECEIVED

1. PLACE OF DEATH o. COUNTY Balto. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Xo Randallstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8903 Liberty Rd.		d. STREET ADDRESS 8903 Liberty Rd.	
3. NAME OF DECEASED (Type or print) First JAMES Middle DONALD Last KERSHNER		4. DATE OF DEATH Month Feb. Day 9, Year 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 18, 1907
9. AGE (In years last birthday) 49 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Personnel Director		10b. KIND OF BUSINESS OR INDUSTRY Oil Company	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME James Alexander Kershner		14. MOTHER'S MAIDEN NAME Della Eva Shumaker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Frances L. Kershner - 8903 Liberty Rd.		Address Randallstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Hypertensive and arteriosclerotic coarse (c) cardiovascular disease DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH sudden death 10 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 25 March, 1949 , to 9 Feb , 1957, that I last saw the deceased alive on 8 Feb , 1957, and that death occurred at 5:15 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Ernest S. Cross Jr.		ADDRESS (Street, city or town, state) 803 Medical Arts Bldg Baltimore	
PHYSICIAN'S NAME (Type) Ernest S. Cross, Jr.		DATE SIGNED 11 Feb 57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 2/12/57	22c. NAME OF CEMETERY OR CREMATORY Green Mount Crem.	22d. LOCATION (City, town, or county) (State) Balto., Md.
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Lickner & Sons - Balto 17th		24a. REC'D BY REGISTRAR DATE 2-13-57	24b. REGISTRAR'S SIGNATURE Dr. Wm. E. Martin

U. S. A. 1957

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1515

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 20yrlmthllds			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First George Middle King Last King				4. DATE OF DEATH Month February Day 19 Year 19 57			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 8, 1882	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months 75 Days 75 Hours 75 Min. 75		IF UNDER 24 HRS. Months 75 Days 75 Hours 75 Min. 75			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer				10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME George King				14. MOTHER'S MAIDEN NAME Anna Wagengast			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown				16. SOCIAL SECURITY NO. unknown			
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Infarctive myocardial fibrosis DUE TO (c) Arteriosclerotic cardiovascular disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Obesity							
INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Feb. 4, 19 57 , to Feb. 19, 19 57 , that I last saw the deceased alive on Feb. 19, 19 57 , and that death occurred at 7:30 a.m. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Stella Wachsler				DATE SIGNED SPRING GROVE STATE HOSPITAL 2-19-57			
PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.				ADDRESS (Street, city or town, state) Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 22/2/57		22c. NAME OF CEMETERY OR CREMATORY HOLY REDEEMER CEM.		22d. LOCATION (City, town, or county) (State) BALTO., MD.	
23. FUNERAL DIRECTOR'S SIGNATURE John G. Miller				24a. REC'D BY REGISTRAR FEB 21 '57			
ADDRESS 2334 Jefferson St.				24b. REGISTRAR'S SIGNATURE W. L. Leach			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 25 1967

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01514

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY Balto.	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Woodlawn		LENGTH OF STAY (in this place) 6 Mos.		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Woodlawn			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 6729 Windsor Mill Rd.				STREET ADDRESS (If rural give location) 6729 Windsor Mill Rd.			
3. NAME OF DECEASED (Type or Print) WALTER C. KIRK				4. DATE OF DEATH Feb. 15 19 57			
5. SEX Male		6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widower		8. DATE OF BIRTH June 20, 1887	
				9. AGE last birthday 69 yrs.		10. IF UNDER 1 YEAR Months Days	
						11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Hebbville, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William H. Kirk				14. MOTHER'S MAIDEN NAME Anna Wallace			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. 219-03-0276		17. INFORMANT & ADDRESS Mrs. Eleanor Mohler			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION 6729 Windsor Mill Rd.		INTERVAL BETWEEN ONSET AND DEATH 7-8 mos	
199.7 IMMEDIATE CAUSE (A) Metastatic Carcinoma							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 7/15, 19 57, to 7/15, 19 57, that I last saw the deceased alive on 2/11, 19 57, and that death occurred at 12 noon, from the causes and on the date stated above.							
SIGNATURE Milton Schlenker				ADDRESS (Street, city, town, state) 6410 Windsor Mill Rd. Balto. Md.		DATE SIGNED Feb. 7, 1957	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Feb. 18, 1957		NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. REC'D BY REGISTRAR DATE FEB 18 1957		REGISTRAR'S SIGNATURE Dr. J. M. C. Martin		25. FUNERAL DIRECTOR'S SIGNATURE E. W. Armacost		ADDRESS 4600 LIBERTY HEIGHTS AVENUE	

CERTIFICATE OF DEATH

1957

1. DATE OF DEATH

2. PLACE OF DEATH

3. SEX

4. AGE

5. OCCUPATION

6. CAUSE OF DEATH

7. MANNER OF DEATH

8. SIGNATURE OF PHYSICIAN

9. SIGNATURE OF REGISTRAR

10. SIGNATURE OF WITNESSES

11. SIGNATURE OF FUNERAL HOME

12. SIGNATURE OF BURIAL PLACE

13. SIGNATURE OF INTERVIEWER

14. SIGNATURE OF CLERK

15. SIGNATURE OF OFFICIAL

16. SIGNATURE OF JUDGE

17. SIGNATURE OF SHERIFF

18. SIGNATURE OF CONSTABLE

19. SIGNATURE OF TOWNSHIP CLERK

20. SIGNATURE OF COUNTY CLERK

21. SIGNATURE OF STATE CLERK

22. SIGNATURE OF U.S. DEPT. OF HEALTH

23. SIGNATURE OF U.S. DEPT. OF AGRICULTURE

24. SIGNATURE OF U.S. DEPT. OF COMMERCE

25. SIGNATURE OF U.S. DEPT. OF EDUCATION

26. SIGNATURE OF U.S. DEPT. OF INTERIOR

27. SIGNATURE OF U.S. DEPT. OF JUSTICE

28. SIGNATURE OF U.S. DEPT. OF LABOR

29. SIGNATURE OF U.S. DEPT. OF NAVY

30. SIGNATURE OF U.S. DEPT. OF STATE

31. SIGNATURE OF U.S. DEPT. OF WAR

32. SIGNATURE OF U.S. DEPT. OF ARMY

33. SIGNATURE OF U.S. DEPT. OF AIR FORCE

34. SIGNATURE OF U.S. DEPT. OF SPACE

35. SIGNATURE OF U.S. DEPT. OF DEFENSE

36. SIGNATURE OF U.S. DEPT. OF ENERGY

37. SIGNATURE OF U.S. DEPT. OF TRANSPORTATION

38. SIGNATURE OF U.S. DEPT. OF AGRICULTURE

39. SIGNATURE OF U.S. DEPT. OF COMMERCE

40. SIGNATURE OF U.S. DEPT. OF EDUCATION

41. SIGNATURE OF U.S. DEPT. OF INTERIOR

42. SIGNATURE OF U.S. DEPT. OF JUSTICE

43. SIGNATURE OF U.S. DEPT. OF LABOR

44. SIGNATURE OF U.S. DEPT. OF NAVY

45. SIGNATURE OF U.S. DEPT. OF STATE

46. SIGNATURE OF U.S. DEPT. OF WAR

47. SIGNATURE OF U.S. DEPT. OF ARMY

48. SIGNATURE OF U.S. DEPT. OF AIR FORCE

49. SIGNATURE OF U.S. DEPT. OF SPACE

50. SIGNATURE OF U.S. DEPT. OF DEFENSE

BUREAU V. 3

FEB 18 1957

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

UNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial; cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01515

1517

Reg. Dist. No. 33

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkton</u>		c. LENGTH OF STAY IN 1b <u>48 yrs. x2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Parsonage Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Nzomi</u> Middle <u>O.</u> Last <u>Kiser</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>18</u> Year <u>1957</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar. 26 1908</u> 48 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Canning Fact.</u>	
11. BIRTHPLACE (State or foreign country) <u>Parkton, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Nelson Taylor</u>		14. MOTHER'S MAIDEN NAME <u>Rose Warner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Claude Kiser, Parkton, Md.</u>	
17. INFORMANT <u>Claude Kiser, Parkton, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331x Cerebral hemorrhage</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>A. M. France</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>A. M. FRANCE</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>2/20/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-21-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Pine Grove E. B. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Parkton, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Hartenstein, New Freedom, Pa.</u>		24a. REC'D BY REGISTRAR <u>2/20/57</u>	
ADDRESS <u>New Freedom, Pa.</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. France</u>	

BUREAU V. S.

FEB 25 1957

RECEIVED

1518

CERTIFICATE OF DEATH

Reg. Dist. No.

37

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MASONIC HOME		d. STREET ADDRESS 2504 BROOKFIELD AVE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MAMIE Middle KOCH Last		4. DATE OF DEATH Month FEB Day 20 Year 1957	
5. SEX FEMALE	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-26-1880
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) PENN.
12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME BENJAMIN SALLER		14. MOTHER'S MAIDEN NAME REGINA NEUMAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 212-01-1281	
17. INFORMANT Frank L. Smith, Cockeysville			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio-Sclerotic Cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Vascular disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 3 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1-20, 1954 , to 2-20, 1957 , that I last saw the deceased alive on 12-20, 1957 , and that death occurred at 9:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cockeysville, Md. DATE SIGNED 2/20/57			
ACTUAL SIGNATURE Walter T. Kees		M.D. Cockeysville, Md.	
PHYSICIAN'S NAME (Type) WALTER T. KEES.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 2-22-57	22c. NAME OF CEMETERY OR CREMATORY Oak Hill	22d. LOCATION (City, town, or county) (State) BALTO Md.
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook Inc 1217 St Paul St.		24a. REC'D BY REGISTRAR DATE 2-21-57	24b. REGISTRAR'S SIGNATURE Frank Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the registrar should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Hall		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Perry Hall Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9335 Belair Rd.		d. STREET ADDRESS 9335 Belair Rd.	
3. NAME OF DECEASED (Type or print) First Michael Middle Kost Last Kost		4. DATE OF DEATH Month Feb Day 14 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 29, 1902
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR: Months 54 Days 14 Hours 19 Min. 57	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ass't Supt.		10b. KIND OF BUSINESS OR INDUSTRY Glen L. Martin	
11. BIRTHPLACE (State or foreign country) Lorain Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Michal Kost		14. MOTHER'S MAIDEN NAME Mary Hudak	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 216-03-5435	
17. INFORMANT Mrs. Billie Kost		Address 9335 Belair Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH Immediate 6 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1 Feb , 1957, to 14 Feb , 1957, that I last saw the deceased alive on 8 Feb 57 , 1957, and that death occurred at 11 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED George D. Edwards, M.D. 9660 Belair Rd. Baltimore, 6, Md. 2-14-57			
ACTUAL SIGNATURE George D. Edwards		PHYSICIAN'S NAME (Type) GEORGE D. EDWARDS, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/18/57	
22c. NAME OF CEMETERY OR CREMATORY St. Joseph Cem.		22d. LOCATION (City, town, or county) (State) Fullerton Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Sarah Home		ADDRESS 7401 Belair Rd. 6	
24a. REC'D BY REGISTRAR FEB 18 1957		24b. REGISTRAR'S SIGNATURE Dr. Walter L. H. H. H.	

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1520

CERTIFICATE OF DEATH

01518

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE				c. LENGTH OF STAY IN 1b 7 MONTHS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MASONIC HOME				d. STREET ADDRESS 6613 REESTERTOWN RD			
3. NAME OF DECEASED (Type or print) EMILY First MAE Middle KREEGER Last				4. DATE OF DEATH FEB Month 18 Day 1957 Year			
5. SEX FEMALE		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JAN 3, 1874	
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME WILLIAM H. H. CULLIMORE				14. MOTHER'S MAIDEN NAME EMILY WARD			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Mr. Thos. J. Cullimore, Sr. Address 57-104 4th Ave. - Glen Burnie			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Arteriosclerosis 443X DUE TO cardio-vascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 6 months						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/21/56 , 19____, to 2/15/57 , 19____, that I last saw the deceased alive on 2/15/57 , 19____, and that death occurred at 6:40 A. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Walter T. Kees		M.D. Cockeysville, Md.		DATE SIGNED 2/18/57			
PHYSICIAN'S NAME (Type) WALTER T. KEES							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/20/57		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		22d. LOCATION (City, town, or county) (State) Woodlawn Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tickner & Sons - North & Pa. Aves				24a. REC'D BY REGISTRAR DATE 2-19-57		24b. REGISTRAR'S SIGNATURE Frank Smith	

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. A bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01519

CERTIFICATE OF DEATH

1431

Reg. Dist. No. 41

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTO.</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>BALTO</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>DUNDALK</u>		LENGTH OF STAY (In this place) <u>37 YRS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1726 LESLIE AVE.</u>				STREET ADDRESS (If rural give location) <u>1726 LESLIE AVE.</u>			
3. NAME OF DECEASED (Type or Print) <u>THOMAS JERE LAU</u>				4. DATE OF DEATH <u>2-21-57</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>JUNE 6, 1896</u>	
9. AGE last birthday <u>60</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CAR INSPECTOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RAILROAD</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>MARTIN D. LAU</u>		14. MOTHER'S MAIDEN NAME <u>HATTIE MOORE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>777-07-7258</u>		17. INFORMANT & ADDRESS <u>CATHERINE S. LAU - SAME</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
163X IMMEDIATE CAUSE (A) <u>CARCINOMA of LEFT LUNG</u>				INTERVAL BETWEEN ONSET AND DEATH <u>6 mos -</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>None</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>HOME</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>Feb 21, 1957</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug. 1956</u> , to <u>Feb. 21, 1957</u> , that I last saw the deceased alive on <u>Feb. 21, 1957</u> , and that death occurred at <u>8:15</u> M., from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		DATE THEREOF <u>2/25/57</u>		NAME OF CEMETERY, OR CREMATORY <u>CAR LAWN</u>		LOCATION (City, town, or county) (State) <u>BALTO CO MD</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24. REC'D BY REGISTRAR <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>6800 Mornington Row - Dundalk 22 Md 21557</u>	
DATE <u>FEB 25 1957</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>[Address]</u>			

01110

CERTIFICATE OF DEATH

DEPT. OF HEALTH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH

MASSACHUSETTS

BUREAU V. S.

FEB 25 1957

RECEIVED

1521

CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY BALTO b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FT. HOWARD c. LENGTH OF STAY IN 1b 38 YRS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION AVENUE A-TODDS FARM		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY BALTO c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BOX 163 ROUTE 10 - BALTO 19 X 2 d. STREET ADDRESS TODDS FARM e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HILJA Middle MARIE Last LEINO		4. DATE OF DEATH Month 2 Day 25 Year 1957	
5. SEX FEM.	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB 19, 1887
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR: Months — Days — Hours — Min. —	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY FINLAND	
11. BIRTHPLACE (State or foreign country) FINLAND		12. CITIZEN OF WHAT COUNTRY? FINLAND	
13. FATHER'S NAME ALEXANDER LEINO		14. MOTHER'S MAIDEN NAME BEETA. (UNK)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) NO (If yes, give war or dates of service) —		16. SOCIAL SECURITY NO. 22044-333	
17. INFORMANT MRS. A. F. KAUFMAN - SAME		Address —	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) —		INTERVAL BETWEEN ONSET AND DEATH 4 days 8 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Dec. 1, 1956 to Feb. 25, 1957 , that I last saw the deceased alive on Feb. 24, 1957 , and that death occurred at 5:20 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE David Owens		ADDRESS (Street, city or town, state) 917 D St. Balto. 19 Md.	
PHYSICIAN'S NAME (Type) David Owens		DATE SIGNED 2/25/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-27-57	22c. NAME OF CEMETERY OR CREMATORY Oak Park	22d. LOCATION (City, town, or county) (State) Balto. Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Walter P. P. P. P. P.		ADDRESS Baltimore, Md.	
24a. REC'D BY REGISTRAR FEB 27 1957		24b. REGISTRAR'S SIGNATURE Dawson L. Selby	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

: 521

BUREAU V. 5

FEB 27 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01521

1522

CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 184 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3401-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 532 W. Mulberry Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHARLES Middle A. Last LIST				4. DATE OF DEATH Month February Day 24 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/18/81		9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months 24 Days 19 Hours 57	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Lunch Room		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank List				14. MOTHER'S MAIDEN NAME Mary Anne Himmler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		(If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. 224-12-5938		17. INFORMANT Address Clin. Rec., Vet. Adm Hosp., Ft. Howard, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF RIGHT LOWER LOBE WITH METASTASIS TO 163X DUE TO LEFT MIDDLE AND UPPER RIGHT Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) PNEUMONIA RIGHT LUNG DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 24, 1956 , to February 24, 1957 , and that death occurred at 3:00 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Roland D. Ponce de Leon M.D.				ADDRESS (Street, city or town, state) Veterans Administration Hospital DATE SIGNED 2/24/57			
PHYSICIAN'S NAME (Type) ROLAND D. PONCE de LEON, M. D.				Fort Howard, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-27-57		22c. NAME OF CEMETERY OR CREMATORY Louden Park		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Blight, Inc ADDRESS 6009 Harford Rd, Baltimore, Md.				24a. REC'D BY REGISTRAR MAR 4 1957		24b. REGISTRAR'S SIGNATURE Lawson L. Lasky	

- 58 -

BUREAU V. S. S.

MAR 5 1957

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

31

1523

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marriottsville		c. LENGTH OF STAY IN 1b 2 Weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marriottsville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HARVEY Middle Last LIVESAY				4. DATE OF DEATH Month February Day 20 Year 19 57			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 15, 1951		9. AGE (In years last birthday) 5 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Tennessee		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Christie Livesay				14. MOTHER'S MAIDEN NAME Jane Hilbert			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Ronnie Johnson - Shadville, Tenn.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive incineration of body 916.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Conflagration of house					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. Feb. 20, 19 57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Marriottsville Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE William V. Lovitt, Jr.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-23-57		22c. NAME OF CEMETERY OR CREMATORY Family Cemetery		22d. LOCATION (City, town, or county) (State) Shadville, Tenn.	
23. FUNERAL DIRECTOR'S SIGNATURE C. Harry Allen				24a. REC'D BY REGISTRAR 2-23-57		24b. REGISTRAR'S SIGNATURE Dr. Wm. Martin	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1881

RECEIVED
MAR 1 1957
BUREAU V. 8

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01523

Reg. Dist. No.

31

1524

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marriottsville			c. LENGTH OF STAY IN 1b 2 Weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marriottsville		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First JANE Middle Last LIVESAY				Month February Day 20 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 4, 1933	
9. AGE (In years last birthday) 23 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Tennessee		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME George Hilbert				14. MOTHER'S MAIDEN NAME Cornie Williams			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. unk		17. INFORMANT Address Cornie Johnson, Sneedville, Tenn.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive incineration of body DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Conflagration of house					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. Feb. 20 19 57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Marriottsville Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE William V. Lovitt, Jr.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.				DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 2/20/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-23-57		22c. NAME OF CEMETERY OR CREMATORY Family Cemetery		22d. LOCATION (City, town, or county) (State) Sneedville, Tenn.	
23. FUNERAL DIRECTOR'S SIGNATURE C. Harry Ware, Sneedville, Md.				24a. REC'D BY REGISTRAR 2-23-57		24b. REGISTRAR'S SIGNATURE Dr. Jm. Martin	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the health officer prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF NEW YORK - DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

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BUREAU V. H.

MAR 1 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the funeral director prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01524

Reg. Dist. No.

31

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marriottsville	c. LENGTH OF STAY IN 1b 2 Weeks	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marriottsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JANICE Middle LIVESAY Last LIVESAY		4. DATE OF DEATH Month February Day 20 Year 19 57	
5. SEX F.	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 6, 1955
9. AGE (In years last birthday) 1 yrs.		10. IF UNDER 1 YEAR Months 2 Days 14	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Tennessee
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Charles Livesay		14. MOTHER'S MAIDEN NAME Jane Hilbert	
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Cornie Johnson - Shredville, Tenn.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive incineration of body DUE TO 916.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Conflagration of house	
20c. TIME OF INJURY Month, Day, Year Hour a. m. Feb. 20 1957 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Marriottsville Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE William V. Lovitt, Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 2/20/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-23-57	
22c. NAME OF CEMETERY OR CREMATORY Family Cemetery		22d. LOCATION (City, town, or county) (State) Shredville, Tenn.	
23. FUNERAL DIRECTOR'S SIGNATURE C. Harry Warr - Shredville, Md.		ADDRESS Shredville, Tenn.	
24a. REC'D BY REGISTRAR 2-23-57		24b. REGISTRAR'S SIGNATURE Dr. Wm. Masterson	

RECEIVED

MAR 1 1957

BUREAU V. S.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rossville,				c. LENGTH OF STAY IN 1b life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Susan Middle Newbold Last Mace				4. DATE OF DEATH Month Feb. Day 4 Year 57			
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 3, 1869	
9. AGE (In years last birthday) 87		IF UNDER 1 YEAR Months 8 Days 1 Hours 15 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Baltimore Co. Md.				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Samuel Newbold Trump				14. MOTHER'S MAIDEN NAME Juliet Candy Brown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Otis Mace Phoenix, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral arteriosclerosis Thrombosis 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral arteriosclerosis DUE TO (c) Generalized arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 420.1 Myocardial infarction old 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 12 , 19 48 , to Feb 4 , 19 57 , that I last saw the deceased alive on Mar 2 , 19 56 , and that death occurred at 7:00 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6 E. Read St. DATE SIGNED Feb 4, 1957 ACTUAL SIGNATURE Edward F. Cotter M.D. PHYSICIAN'S NAME (Type) Dr. Edward F. Cotter							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 6, 1957		22c. NAME OF CEMETERY OR CREMATORY Druid Ridge		22d. LOCATION (City, town, or county) (State) Pikesville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons Inc. 1900 Eutaw Place				24a. REC'D BY REGISTRAR FEB 5 1957		24b. REGISTRAR'S SIGNATURE Mrs. A. L. Ruffin	

CERTIFICATE OF DEATH

1956

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Name of Deceased		Date of Birth		Sex		Race		Marital Status		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
John A. Smith		1915		Male		White		Married		Maryland		Maryland		Heart Disease		1956		10:00 AM		Home		J. A. Smith		J. A. Smith	
Occupation		Education		Religion		Political Party		Social Security No.		Maiden Name		Previous Residence		Previous Cause of Death		Previous Date of Death		Previous Time of Death		Previous Place of Death		Previous Signature of Physician		Previous Signature of Registrar	
Teacher		High School		Catholic		Democratic		123456789		None		None		None		None		None		None		None		None	
Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Date of Death		Time of Death		Place of Death	
1956		10:00 AM		Home		J. A. Smith		J. A. Smith		1956		10:00 AM		Home		J. A. Smith		J. A. Smith		1956		10:00 AM		Home	

BUREAU V. 3

FEB 5 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01526

1527

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stevenson		c. LENGTH OF STAY IN 1b 30 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Valley Rd.		d. STREET ADDRESS Valley Rd.	
3. NAME OF DECEASED (Type or print) First Elizabeth R. Middle Maddox Last		4. DATE OF DEATH Month Feb. Day 12 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 3, 1876
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Balto. Co. Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William E. Maddox		14. MOTHER'S MAIDEN NAME Frances Hughes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Harry E. Maddox		Address Stevenson, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 24 hours 4 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 10th, 1953 , to Feb. 12th, 1957 , that I last saw the deceased alive on February 11th, 1957 , and that death occurred at 6:50 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE James A. Miller M.D.		ADDRESS (Street, city or town, state) Pikesville-8, Md.	
PHYSICIAN'S NAME (Type) Dr. James A. Miller		DATE SIGNED 2/12/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Feb. 14, 1957	22c. NAME OF CEMETERY OR CREMATORY Ebenezer Methodist	22d. LOCATION (City, town, or county) (State) Balto. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Lanahan Funeral Home		ADDRESS 7401 Belair Rd.	
24a. REC'D BY REGISTRAR DATE 2/14/57		24b. REGISTRAR'S SIGNATURE Dr. A. M. Bacon	

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

00000

BUREAU V. 2

SEP 14 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1437

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01527

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE N. Y. b. COUNTY Brooklyn	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Balto. Highlands (" 1 Wk		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New York City	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3006 Georgia Ave (27)		d. STREET ADDRESS 6429 2nd Ave 69X-3	
e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Salvatore Marzano		4. DATE OF DEATH Month Feb. Day 24 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mch, 14, 1880
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? ?	
13. FATHER'S NAME ? Marzano		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No	
17. INFORMANT Josephine Nykyforchyn		Address 1331 Cambra St	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Geo. S. M. Kieffer</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Geo. S. M. Kieffer M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED Feb. 24. 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-28-57	
22c. NAME OF CEMETERY OR CREMATORY Mount Calvary		22d. LOCATION (City, town, or county) (State) Brooklyn, New York	
23. FUNERAL DIRECTOR'S SIGNATURE Vanella Funeral Home-33 Madison St., New York, N. Y.		24a. REC'D BY REGISTRAR FEB 27 1957	
24b. REGISTRAR'S SIGNATURE <i>Dr. Geo. S. M. Kieffer</i>			

STATE DEPARTMENT OF HEALTH—BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

FEB 27 1957

RECEIVED

1528

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RANDALLSTOWN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RANDALLSTOWN	
c. LENGTH OF STAY IN 1b 6 YEARS		d. STREET ADDRESS DEER PARK RD.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION DEER PARK RD.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First VERONICA Middle (FRONIE) Last MATHER		4. DATE OF DEATH Month FEB. Day 13 Year 1957	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 5 1875
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEKEEPING		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME JOHN HOLLMAN		14. MOTHER'S MARDEN NAME CECELIA ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MRS VERA KUSTERER Address DEER PARK RD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL VASCULAR ACCIDENT - SIDE 443x DUE TO 4 DAYS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) HYPERTENSIVE C.V. DISEASE - SEVERE DUE TO 10 YEARS (c) GENERALIZED ARTERIOSCLEROSIS - DUE TO 15 YEARS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JUNE , 1950, to FEB 13 , 1957, that I last saw the deceased alive on FEB 13 , 1957, and that death occurred at 10:00 M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas E. Wheeler M.D. 3601 Wynny Rd.		DATE SIGNED 2/13/57	
PHYSICIAN'S NAME (Type) THOMAS E. WHEELER MD.		Balto 7-Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF FEB. 16, 1957	22c. NAME OF CEMETERY OR CREMATORY CATHEDRAL CEMETERY	22d. LOCATION (City, town, or county) (State) BALTIMORE, MD.
23. FUNERAL DIRECTOR'S SIGNATURE Lo. Vernon Lemmon ADDRESS 4611 PK. HEIGHTS BALTO. MD.		24a. REC'D BY REGISTRAR DATE 2/14/57	24b. REGISTRAR'S SIGNATURE Dr. Wm. Martin

CERTIFICATE OF DEATH

1957

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

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BUREAU V. 5

1957

RECEIVED

CATHOLIC CHURCH

1957

ADJ. CLERK - BALTIMORE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1529

CERTIFICATE OF DEATH

01529

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Notch Cliff near Towson		c. LENGTH OF STAY IN IB 2 1/2 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Villa Maria, Glenarm Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Sister Mary Zita Maushardt Middle Last 		4. DATE OF DEATH Month Feb. Day 23 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 5, 1877
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) teacher		10b. KIND OF BUSINESS OR INDUSTRY 	
11. BIRTHPLACE (State or foreign country) Pittsburg, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Adam Maushardt		14. MOTHER'S MAIDEN NAME Lena Koernaly	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service 		16. SOCIAL SECURITY NO. 	
17. INFORMANT Sr. Mary Clara Notch Cliff, Md.		Address 	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) (County) (State) 	
21. I certify that I attended the deceased from June 6 , 19 54 , to Feb. 23 , 19 57 , that I last saw the deceased alive on Feb. 19 , 19 57 , and that death occurred at 11.00 M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles F. O'Donnell M.D.		DATE SIGNED & 7501 York Rd. Towson, Md.	
PHYSICIAN'S NAME (Type) Dr. Charles F. O'Donnell			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 2-26-57	22c. NAME OF CEMETERY OR CREMATORY VILLA MARIA CEM.	22d. LOCATION (City, town, or county) (State) NOTCH CLIFF NRTOWSON, MD
23. FUNERAL DIRECTOR'S SIGNATURE Charles S. Seiler		24a. REC'D BY REGISTRAR 901 S. CONKLING ST. BALTO., 24, MD.	24b. REGISTRAR'S SIGNATURE Mabel Gray

子

BUREAU V. S.

FEB 28 1957

RECEIVED

DATE: 11/11/11

Reg. Dist. No.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE PENNSYLVANIA b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PHILADELPHIA 75x3	
d. NAME OF HOSPITAL (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS 1118 NORTH MANSTON	
3. NAME OF DECEASED (Type or print) First Middle Last DANIEL A McBRIDE		4. DATE OF DEATH Month Day Year FEBRUARY 10 19 57	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-19-93
		9. AGE (In years last birthday) yrs. 63	IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY REFRIGERATION	11. BIRTHPLACE (State or foreign country) PENNSYLVANIA
13. FATHER'S NAME JOHN J. McBRIDE		14. MOTHER'S MAIDEN NAME MARY GALLAGER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES	16. SOCIAL SECURITY NO. WW-1	17. INFORMANT Address CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF ESOPHAGUS 150x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH UNKNOWN
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from January 23, 1957, to February 10, 1957, and that death occurred at 7:05 a.m., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED VAH FORT HOWARD, MARYLAND 2-10-57			
ACTUAL SIGNATURE <i>George C. Godfrey</i> M.D.		PHYSICIAN'S NAME (Type) George C. Godfrey M.D. VAH FORT HOWARD, MARYLAND 2-10-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 2-11-57	22c. NAME OF CEMETERY OR CREMATORY HOLY CROSS CEMETERY	22d. LOCATION (City, town, or county) (State) PHILADELPHIA, PENNSYLVANIA
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. Cook-Blight Inc.</i> ADDRESS 6009 HARFORD ROAD, BALTIMORE 11, MARYLAND		24a. REC'D BY REGISTRAR DATE 3 13 1957	24b. REGISTRAR'S SIGNATURE <i>Samuel L. Fiske</i>

SHIPPED TO: PAUL NORKAS FUNERAL HOME, 1400 N. 29th ST., PHILADELPHIA 21, PENNSYLVANIA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

VS A15 (4)
15M 9/55

CERTIFICATE OF DEATH

1957

<p>NAME OF DECEASED</p>		<p>DATE OF DEATH</p>	
<p>AGE</p>		<p>SEX</p>	
<p>PLACE OF BIRTH</p>		<p>DATE OF BIRTH</p>	
<p>EDUCATION</p>		<p>OCCUPATION</p>	
<p>CAUSE OF DEATH</p>		<p>IMMEDIATE CAUSE</p>	
<p>UNDERLYING CAUSE</p>		<p>PERMANENT CAUSE</p>	
<p>DATE OF EXAMINATION</p>		<p>PLACE OF EXAMINATION</p>	
<p>SIGNATURE OF PHYSICIAN</p>		<p>SIGNATURE OF REGISTRAR</p>	
<p>DATE OF SIGNATURE</p>		<p>DATE OF SIGNATURE</p>	

BUREAU V. 2

FEB 13 - 1957

RECEIVED

1531

CERTIFICATE OF DEATH

Reg. Dist. No. 38

Item 9 FilmG210 2-18-57 et

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Baltimore	MARYLAND	STATE Maryland	COUNTY Baltimore
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Rural: Towson	LENGTH OF STAY (in this place) 2mo 8da.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Eudowood Sanatorium Towson 4, Maryland		STREET ADDRESS (If rural give location) 31014 10 E. Read St Balt Md	
3. NAME OF DECEASED: (First) MONICA (Middle) M. (Last) MCCARTHY		4. DATE OF DEATH: (Month) Feb (Day) 10 (Year) 1957	
5. SEX: F	6. COLOR OR RACE: W	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): single	8. DATE OF BIRTH: May 13, 1891
9. AGE last birthday: 66 yrs.		10. BIRTHPLACE (State or foreign country): Balto. md	
11. BIRTHPLACE (State or foreign country): Balto. md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: John McCarthy		14. MOTHER'S MAIDEN NAME: Ellen Coleman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: Personal History	
17. INFORMANT & ADDRESS: Hospital Records, Eudowood Sanatorium			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval Between Onset And Death	
Immediate cause (a) 600.0 Pyonephrosis left Pyelonephritis Rt ruptured Sall Bladder peritonitis		15 days	
Antecedent causes (b) 002.2 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION: 2/13/57		19b. MAJOR FINDINGS OF OPERATION Pulmonary Tuberculosis 3 mo	
20. AUTOPSY? Yes			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 12-2 , 19 56 , to 2/10 , 19 57 , that I last saw the deceased alive on 2/9 , 19 57 , and that death occurred at 3.05 AM from the causes and on the date stated above.			
SIGNATURE Milton B. Kuo		DATE SIGNED	
23. BURIAL CREMATION, REMOVAL (Specify)		NAME OF CEMETERY OR CREMATORY	
Burial		New Cathedral	
DATE REC'D BY LOCAL REGISTRAR 2/14/57		REGISTRAR'S SIGNATURE Mabel Gray	
24. FUNERAL DIRECTOR		ADDRESS	
W. W. Meakes		Don R. N. Calvert St	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Body Released by Dr. R. L. Hudson to be autopsied at Church
Hend Hosp. by Dr. V. Norwood

BUREAU V. 3

SEP 14 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01532

1532

CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 193 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. STREET ADDRESS 1430 Linden Avenue							
3. NAME OF DECEASED (Type or print) First LAYTON Middle (NMI) Last MC DANIEL				4. DATE OF DEATH Month February Day 8 Year 57			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 5, 1896	
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor				10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Centreville, Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME John McDaniel				14. MOTHER'S MAIDEN NAME Georgiana Cooper			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		(If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. 212-10-3024		17. INFORMANT Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHRONIC NEPHROSCLEROSIS BILATERAL 446X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PULMONARY EDEMA DUE TO (c) ANASARCA HYPOPROTEINEMIA INTERVAL BETWEEN ONSET AND DEATH UNKNOWN TERMINAL UNKNOWN							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from July 30, 1956 , to February 8, 1957 , and that death occurred at 3:05 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ROLANDO D. PONCE DE LEON, M.D., VAH, FORT HOWARD, MARYLAND 2/9/57							
ACTUAL SIGNATURE ROLANDO D. PONCE DE LEON, M.D., VAH, FORT HOWARD, MARYLAND							
PHYSICIAN'S NAME (Type) ROLANDO D. PONCE DE LEON, M.D., VAH, FORT HOWARD, MARYLAND							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/12/57		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law Funeral Home, 802-04 Madison Ave. Baltimore, 1, Md.				ADDRESS		24a. REC'D BY REGISTRAR Feb. 12-57	
				24b. REGISTRAR'S SIGNATURE Dawson L. Farber			

CERTIFICATE OF DEATH

1957

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Manner of Death	
John Doe		Male		45		Jan 1, 1912		New York City		1234 Main St		Heart Disease		Natural	
Occupation		Education		Marital Status		Date of Marriage		Date of Death		Time of Death		Place of Death		Physician	
Teacher		High School		Married		1935		Jan 15, 1957		10:00 AM		St. Mary's Hospital		Dr. Smith	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Informant		Signature of Informant		Signature of Informant		Signature of Informant		Signature of Informant	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. 3

19 14 1957

RECEIVED

1533

CERTIFICATE OF DEATH

Reg. Dist. No.

33

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u>		c. LENGTH OF STAY IN TB <u>15 months</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>GEORGE LESTER MCKEE</u>		4. DATE OF DEATH Month Day Year <u>February 1 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 10 1898</u>
9. AGE (In years last birthday) <u>59</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bartender</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Perry McKee</u>		14. MOTHER'S MAIDEN NAME <u>Minnie A. Grogling</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>299-01-0168</u>	
17. INFORMANT <u>Mrs. May McKee</u>		Address <u>141 Wilgate Road, Owings Mills, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 493X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pneumonia</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>1 week</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>October</u> , 19 <u>55</u> , to <u>Feb. 1</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Feb. 1</u> , 19 <u>57</u> , and that death occurred at <u>11:55 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Clarence E. McWilliams</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>Reisterstown, Maryland Feb. 2, 1957</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>Feb. 5, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Greenmount</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.F. Eline & Sons, Reisterstown, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>2-4-57</u>	
24b. REGISTRAR'S SIGNATURE <u>Mary B. Eline</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1957

Form with fields for Name, Sex, Age, Race, Date of Birth, Date of Death, Cause of Death, and other medical details. The text is mostly illegible due to blurring and bleed-through.

BUREAU V. 3

FEB 5 1957

RECEIVED

Form with fields for Registrar, Date, and other administrative details. The text is mostly illegible due to blurring and bleed-through.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01534

Reg. Dist. No.

35

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md b. COUNTY Balto	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural (Parkton)		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) (In an automobile)		d. STREET ADDRESS 5721 Highgate Drive 3V014	
3. NAME OF DECEASED (Type or print) Louis Robert Milland		4. DATE OF DEATH Month Feb Day 7 Year 19 57	
5. SEX m	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 17 1914
9. AGE (In years last birthday) 42 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Fish Laundry	
11. BIRTHPLACE (State or foreign country) Balto		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Robert Milland		14. MOTHER'S MAIDEN NAME Lsa Mills	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give year of dates of service) WW II		16. SOCIAL SECURITY NO. 214-01-8483	
17. INFORMANT Lenna Lee Milland		Address Highgate 5721 Drive	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carbon monoxide poisoning 973.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE A. M. France M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) A. M. France		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/10/57	
22c. NAME OF CEMETERY OR CREMATORY Druid Ridge		22d. LOCATION (City, town, or county) (State) Balto Md	
23. FUNERAL DIRECTOR'S SIGNATURE Young Byers		24a. REC'D BY REGISTRAR Chester L. Fulton	
ADDRESS 5005 W. Hyatt Ave		DATE 2-13-57	

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BUREAU W. S.

FEB 14 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01535

1535

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville 28				c. LENGTH OF STAY IN 1b 28 52			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2729 Frederick Road				d. STREET ADDRESS 2729 Frederick Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last MARY CATHERINE MILLER				4. DATE OF DEATH Month Day Year Feb. 4, 1957 19			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-20-1899	9. AGE (In years last birthday) 57 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Granite, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John W. Boone				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address George B. Miller, Catonsville, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Failure 199.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Diffuse Metastatic Carcinoma DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 5 wks 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/17 , 19 56 , to 2/4 , 19 57 , that I last saw the deceased alive on 2/4 , 19 57 , and that death occurred at M , from the causes and on the date stated above.							
ACTUAL SIGNATURE Victor J. Zeng		M.D. 715 Freshfield Ave - Balt 28		ADDRESS (Street, city or town, state)		DATE SIGNED 2/5/57	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-6-57		22c. NAME OF CEMETERY OR CREMATORY Good Shepherd		22d. LOCATION (City, town, or county) (State) Ellicott City, Md	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md.				24a. REC'D BY REGISTRAR DATE 2/7 57		24b. REGISTRAR'S SIGNATURE W. J. ...	

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85. *Chlorophyll*

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1. *Journal of Management Studies*, 1997, 34, 1, 1-14.

BUREAU V. S.

7 FEB 1957

RECEIVED

1536 CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparrows Point</u>		c. LENGTH OF STAY IN 1b <u>40 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>813 J Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>E.</u> Last <u>Marsh Mitchell</u>		4. DATE OF DEATH Month <u>February</u> Day <u>16</u> Year <u>19 57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 8, 1889</u>
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>16</u> Hours <u>16</u> Min.	IF UNDER 24 HRS. Hours <u>16</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wadesbor, N. Carolina</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry Chavis</u>		14. MOTHER'S MAIDEN NAME <u>Mariah Chavis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>10777 Main St. Balt 22 Md</u>	
17. INFORMANT <u>Carter Mitchell</u>		Address <u>813 J Street</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) <u>Diabetes Mellitus</u> (c) <u>260x</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Diabetes Mellitus</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>10</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>10777 Main St. Balt 22 Md</u>	20f. (City or town) (County) (State) <u>Baltimore</u>
21. I certify that I attended the deceased from <u>July 19, 1956</u> to <u>February 16, 1957</u> , that I last saw the deceased alive on <u>February 16, 1957</u> , and that death occurred at <u>10 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>10777 Main St. Balt 22 Md</u> DATE SIGNED <u>Feb 22 1957</u>			
ACTUAL SIGNATURE <u>Dr. Thomas</u>		PHYSICIAN'S NAME (Type) <u>Joseph H. Thomas</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/19/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Carver Memorial Park</u>	22d. LOCATION (City, town, or county) (State) <u>Prince George Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>CHARLES R. LAW</u>		ADDRESS <u>802-04 Madison Ave. Balto.</u>	
24a. REC'D BY REGISTRAR <u>Feb 20 1957</u>		24b. REGISTRAR'S SIGNATURE <u>L. Farkes</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. F.

FEB 20 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01537

1537

CERTIFICATE OF DEATH

Reg. Dist. No.

30

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b 52 Catonsville		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 617 Wallerson Rd. d. STREET ADDRESS 617 Wallerson Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Arthur Middle Montooth Last Montooth		4. DATE OF DEATH Month Feb. Day 26 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 4 1875
9. AGE (In years last birthday) 81 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	11. BIRTHPLACE (State or foreign country) York Co. Penna
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Railroad Conductor	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Barnabas Montooth		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Kenneth Montooth		Address as above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Dis. DUE TO 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 1 yr.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 25 , 19 57 , to Feb. 26 , 19 57 , that I last saw the deceased alive on Feb. 26 , 19 57 , and that death occurred at 4:30 P. M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE I EARL PASS		ADDRESS (Street, city or town, state) 4001 Wilkens Ave Baltimore 29 Md.	
PHYSICIAN'S NAME (Type) I EARL PASS, M.D.		DATE SIGNED 2-26-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF March 1 1957	22c. NAME OF CEMETERY OR CREMATORY Craley Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore Penna
23. FUNERAL DIRECTOR'S SIGNATURE Wm J. Dickma		24a. REC'D BY REGISTRAR 2-28-57	24b. REGISTRAR'S SIGNATURE R. H. Hedrick

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Faint text]</p>		<p>2. SEX [Faint text]</p>	
<p>3. AGE [Faint text]</p>		<p>4. RACE [Faint text]</p>	
<p>5. DATE OF DEATH [Faint text]</p>		<p>6. PLACE OF DEATH [Faint text]</p>	
<p>7. CAUSE OF DEATH [Faint text]</p>		<p>8. MANNER OF DEATH [Faint text]</p>	
<p>9. SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>10. SIGNATURE OF REGISTRAR [Faint text]</p>	
<p>11. SIGNATURE OF WITNESS [Faint text]</p>		<p>12. SIGNATURE OF DECEASED [Faint text]</p>	
<p>13. SIGNATURE OF DECEASED [Faint text]</p>		<p>14. SIGNATURE OF DECEASED [Faint text]</p>	
<p>15. SIGNATURE OF DECEASED [Faint text]</p>		<p>16. SIGNATURE OF DECEASED [Faint text]</p>	
<p>17. SIGNATURE OF DECEASED [Faint text]</p>		<p>18. SIGNATURE OF DECEASED [Faint text]</p>	
<p>19. SIGNATURE OF DECEASED [Faint text]</p>		<p>20. SIGNATURE OF DECEASED [Faint text]</p>	
<p>21. SIGNATURE OF DECEASED [Faint text]</p>		<p>22. SIGNATURE OF DECEASED [Faint text]</p>	
<p>23. SIGNATURE OF DECEASED [Faint text]</p>		<p>24. SIGNATURE OF DECEASED [Faint text]</p>	
<p>25. SIGNATURE OF DECEASED [Faint text]</p>		<p>26. SIGNATURE OF DECEASED [Faint text]</p>	
<p>27. SIGNATURE OF DECEASED [Faint text]</p>		<p>28. SIGNATURE OF DECEASED [Faint text]</p>	
<p>29. SIGNATURE OF DECEASED [Faint text]</p>		<p>30. SIGNATURE OF DECEASED [Faint text]</p>	
<p>31. SIGNATURE OF DECEASED [Faint text]</p>		<p>32. SIGNATURE OF DECEASED [Faint text]</p>	
<p>33. SIGNATURE OF DECEASED [Faint text]</p>		<p>34. SIGNATURE OF DECEASED [Faint text]</p>	
<p>35. SIGNATURE OF DECEASED [Faint text]</p>		<p>36. SIGNATURE OF DECEASED [Faint text]</p>	
<p>37. SIGNATURE OF DECEASED [Faint text]</p>		<p>38. SIGNATURE OF DECEASED [Faint text]</p>	
<p>39. SIGNATURE OF DECEASED [Faint text]</p>		<p>40. SIGNATURE OF DECEASED [Faint text]</p>	
<p>41. SIGNATURE OF DECEASED [Faint text]</p>		<p>42. SIGNATURE OF DECEASED [Faint text]</p>	
<p>43. SIGNATURE OF DECEASED [Faint text]</p>		<p>44. SIGNATURE OF DECEASED [Faint text]</p>	
<p>45. SIGNATURE OF DECEASED [Faint text]</p>		<p>46. SIGNATURE OF DECEASED [Faint text]</p>	
<p>47. SIGNATURE OF DECEASED [Faint text]</p>		<p>48. SIGNATURE OF DECEASED [Faint text]</p>	
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<p>51. SIGNATURE OF DECEASED [Faint text]</p>		<p>52. SIGNATURE OF DECEASED [Faint text]</p>	
<p>53. SIGNATURE OF DECEASED [Faint text]</p>		<p>54. SIGNATURE OF DECEASED [Faint text]</p>	
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<p>57. SIGNATURE OF DECEASED [Faint text]</p>		<p>58. SIGNATURE OF DECEASED [Faint text]</p>	
<p>59. SIGNATURE OF DECEASED [Faint text]</p>		<p>60. SIGNATURE OF DECEASED [Faint text]</p>	
<p>61. SIGNATURE OF DECEASED [Faint text]</p>		<p>62. SIGNATURE OF DECEASED [Faint text]</p>	
<p>63. SIGNATURE OF DECEASED [Faint text]</p>		<p>64. SIGNATURE OF DECEASED [Faint text]</p>	
<p>65. SIGNATURE OF DECEASED [Faint text]</p>		<p>66. SIGNATURE OF DECEASED [Faint text]</p>	
<p>67. SIGNATURE OF DECEASED [Faint text]</p>		<p>68. SIGNATURE OF DECEASED [Faint text]</p>	
<p>69. SIGNATURE OF DECEASED [Faint text]</p>		<p>70. SIGNATURE OF DECEASED [Faint text]</p>	
<p>71. SIGNATURE OF DECEASED [Faint text]</p>		<p>72. SIGNATURE OF DECEASED [Faint text]</p>	
<p>73. SIGNATURE OF DECEASED [Faint text]</p>		<p>74. SIGNATURE OF DECEASED [Faint text]</p>	
<p>75. SIGNATURE OF DECEASED [Faint text]</p>		<p>76. SIGNATURE OF DECEASED [Faint text]</p>	
<p>77. SIGNATURE OF DECEASED [Faint text]</p>		<p>78. SIGNATURE OF DECEASED [Faint text]</p>	
<p>79. SIGNATURE OF DECEASED [Faint text]</p>		<p>80. SIGNATURE OF DECEASED [Faint text]</p>	
<p>81. SIGNATURE OF DECEASED [Faint text]</p>		<p>82. SIGNATURE OF DECEASED [Faint text]</p>	
<p>83. SIGNATURE OF DECEASED [Faint text]</p>		<p>84. SIGNATURE OF DECEASED [Faint text]</p>	
<p>85. SIGNATURE OF DECEASED [Faint text]</p>		<p>86. SIGNATURE OF DECEASED [Faint text]</p>	
<p>87. SIGNATURE OF DECEASED [Faint text]</p>		<p>88. SIGNATURE OF DECEASED [Faint text]</p>	
<p>89. SIGNATURE OF DECEASED [Faint text]</p>		<p>90. SIGNATURE OF DECEASED [Faint text]</p>	
<p>91. SIGNATURE OF DECEASED [Faint text]</p>		<p>92. SIGNATURE OF DECEASED [Faint text]</p>	
<p>93. SIGNATURE OF DECEASED [Faint text]</p>		<p>94. SIGNATURE OF DECEASED [Faint text]</p>	
<p>95. SIGNATURE OF DECEASED [Faint text]</p>		<p>96. SIGNATURE OF DECEASED [Faint text]</p>	
<p>97. SIGNATURE OF DECEASED [Faint text]</p>		<p>98. SIGNATURE OF DECEASED [Faint text]</p>	
<p>99. SIGNATURE OF DECEASED [Faint text]</p>		<p>100. SIGNATURE OF DECEASED [Faint text]</p>	

BUREAU V. 1

MAR 1 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01538

1432

CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTO.</u>		STATE <u>Md</u> COUNTY <u>BALTO.</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		STREET ADDRESS		(If rural give location)	
TOWN <u>DUNDALK</u>		<u>30 YRS.</u>		<u>1</u>		<u>2487 FAIRWAY</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2487 FAIRWAY</u>				STREET ADDRESS <u>2487 FAIRWAY</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>JOHN</u> (Middle) <u>(NMI)</u> (Last) <u>MORAVEC</u>				(Month) <u>2</u> (Day) <u>28</u> (Year) <u>57</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		
<u>MALE</u>	<u>WHITE</u>	<u>MARRIED</u>	<u>6/15/1889</u>	<u>67</u> yrs.	Months	Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>MILLWRIGHT</u>		<u>STEEL MFG.</u>		<u>CZECHOSLOVAKIA</u>		<u>CZECHOSLOVAKIA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>UNK.</u>				<u>SOPHOMENA UNK.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>NO</u>		<u>213-07-5931</u>		<u>SALOMENA MORAVEC - SAME</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.0 IMMEDIATE CAUSE (A) <u>Acute Coronary Thrombosis</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary Heart Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>with previous fibrillation</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 2/28</u> , 19 <u>56</u> , to <u>2/28</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3/15</u> , 19 <u>57</u> , and that death occurred at <u>11:20 AM</u> , from the causes and on the date stated above. <u>3/1/57</u>							
SIGNATURE <u>John M. Tellyn</u>		M.D. <u>1801 E. 17th St. Baltimore, Md.</u>		ADDRESS (Street, city, town, state)		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Removal</u>		<u>MAR. 1, 1957</u>		<u>Old Town</u>		<u>Balto. Co. Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>John M. Tellyn</u>		<u>John M. Tellyn</u>		<u>John M. Tellyn</u>		<u>Baltimore, Md.</u>	
DATE <u>MAR 4 1957</u>							

INSTRUCTIONS

1. This form is to be filled out by the physician or other person who has attended the deceased. It should be filled out as soon as possible after death, and should be submitted to the local health department or to the nearest police station. It is not to be filled out for a person who has died of a violent or unnatural cause, or for a person who has died of a disease which is not reportable. It is not to be filled out for a person who has died of a disease which is not reportable. It is not to be filled out for a person who has died of a disease which is not reportable.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

FILE NO.

DEATH CERTIFICATE NUMBER

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE

INTERMEDIATE CAUSE

UNDERLYING CAUSE

DATE OF BIRTH

PLACE OF BIRTH

BUREAU V. S.

MAR 4 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01539

Reg. Dist. No.

1538

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD. b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) BETHLEHEM STEEL CO. HOSPITAL				e. STREET ADDRESS 1239 Forest Rd. #19			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Stephen Middle Moritz Last Moritz				4. DATE OF DEATH Month 2 Day 20 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 17, 1905		9. AGE (In years last birthday) 51 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman Analyst		10b. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel Co. Maryland		11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Moritz				14. MOTHER'S MAIDEN NAME Anna Sibalik			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Tillie Moritz 1239 Forrest Road-19			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion. 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____</p> </div> <div style="width: 35%; text-align: center;"> <p>INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) NONE					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>M.B. Davis M.D.</i>				M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) M.B. Davis, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 23, 1957		22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 2112 Dundalk Ave.				24a. REC'D BY REGISTRAR 21 1957 24b. REGISTRAR'S SIGNATURE <i>Dawson L. Furberg</i>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the funeral director prior to burial, cremation, or removal.

BUREAU V. 3

FEB 25 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01540

CERTIFICATE OF DEATH

Reg. Dist. No. 39

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Baltimore</u> City			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Monkton</u>		<u>3 Mo.</u>		TOWN <u>Baltimore City</u> <u>3Y01-4</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Corbett Road</u>				STREET ADDRESS (If rural give location) <u>4204 Fernhill Ave.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>MARIE</u> (Middle) <u>CLARY</u> (Last) <u>NEIGHBOURS</u>				(Month) <u>February</u> (Day) <u>21</u> (Year) <u>19 57</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>April 17, 1889</u>	<u>67</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>School Teacher</u>		<u>Retired</u>		<u>Mt. Airy, Maryland</u>		<u>USA</u>	
13. FATHER'S NAME <u>Henry W. Clary</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Begnelle</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-34-3381</u>		17. INFORMANT & ADDRESS <u>John O. Neighbours, Jr., Monkton, Md</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						<u>6 months</u>	
153X IMMEDIATE CAUSE (A) <u>Carcinoma of the Colon</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>December 1956</u>		19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of the Colon with extensive metastasis</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>19 50</u> , to <u>February</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>February 12</u> , 19 <u>57</u> , and that death occurred at <u>11:45P</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Willard T. Trabard</u>		ADDRESS (Street, city, town, state) <u>5101 Gwynn Oak Ave. Baltimore, Md.</u>		DATE SIGNED <u>Feb. 22, 57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/25/1957</u>		NAME OF CEMETERY OR CREMATORY <u>St. James Cemetery</u>		LOCATION (City, town, or county) (State) <u>Monkton Maryland</u>	
24. REC'D BY REGISTRAR <u>FEB 25 1957</u>		REGISTRAR'S SIGNATURE <u>Ely. Granch</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Ellsworth Tharmacost</u> ADDRESS <u>4600 Liberty</u>			

CERTIFICATE OF DEATH

1957

STATE OF NEW YORK

DEPARTMENT OF HEALTH

OFFICE OF VITAL RECORDS

ALBANY, N. Y.

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEPARTURE

PLACE OF DEPARTURE

DATE OF RETURN

PLACE OF RETURN

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEPARTURE

PLACE OF DEPARTURE

DATE OF RETURN

PLACE OF RETURN

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEPARTURE

PLACE OF DEPARTURE

BUREAU V. &

FEB 25 1957

RECEIVED

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01541

1540

CERTIFICATE OF DEATH

Reg. Dist. No.

32

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6078 Falls Road</u>				/d. STREET ADDRESS <u>6078 Falls Road-Balto. 9, Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CONRAD</u> Middle <u>J.</u> Last <u>NEWBAR</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>18</u> Year <u>57</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 13, 1865</u>	9. AGE (In years last birthday) <u>91</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired-Record Office</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Towson Court House</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Newbar</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs. Mary N. Riggs-2940 Wyman Parkway-Balto. 11</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Art. Dis.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis</u> DUE TO (c) <u> </u> DUE TO <u> </u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u> </u> <u> </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb.</u> , 19 <u>56</u> to <u>Feb. 18</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Feb. 17</u> , 19 <u>57</u> , and that death occurred at <u>2:00</u> P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4037 FALLS RD.</u> DATE SIGNED <u>2/19/57</u>							
ACTUAL SIGNATURE <u>Edw. L. Ellassman</u> M.D.		PHYSICIAN'S NAME (Type) <u>EDW. L. ELASSMAN</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/20/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pikesville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tickner & Sons - North & Pa. Aves.</u>				24a. REC'D BY REGISTRAR DATE <u>2-19-57</u>		24b. REGISTRAR'S SIGNATURE <u>Dorothy Newell</u>	

CERTIFICATE OF DEATH

540

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. TIME OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF DECEASED		13. SIGNATURE OF WITNESS		14. SIGNATURE OF PHYSICIAN		15. SIGNATURE OF CORONER		16. SIGNATURE OF JURY		17. SIGNATURE OF JUDGE		18. SIGNATURE OF CLERK		19. SIGNATURE OF REGISTRAR		20. SIGNATURE OF OFFICIAL	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

01542

38

1541

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rodgers Forge		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XO Rodgers Forge			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 263 Rodgers Forge Rd.				d. STREET ADDRESS 263 Rodgers Forge Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARGARET Middle BARKER Last NORTEN				4. DATE OF DEATH Month Feb. Day 27 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 4, 1874	
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months 82 Days 82 Hours 82 Min. 82		IF UNDER 24 HRS. Months 82 Days 82 Hours 82 Min. 82			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Leonard Barker				14. MOTHER'S MAIDEN NAME Sarah Ann Norris			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -		16. SOCIAL SECURITY NO. -		17. INFORMANT Address Miss Ruth Northen - 263 Rodgers Forge Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Sudden. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour 19 a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Charles F. O'Donnell				DATE SIGNED			
EXAMINER'S NAME (Type) Charles F. O'Donnell				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/2/57		22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem.		22d. LOCATION (City, town, or county) (State) Pikesville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Lickner & Sons - Balto. 17, Md.				24a. REC'D BY REGISTRAR DATE 3/1/57		24b. REGISTRAR'S SIGNATURE Matel Krupp	

MEDICAL CERTIFICATION

RECEIVED

1957 2 10

BUREAU V. 3

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1957

1. NAME OF DECEASED [REDACTED]		2. SEX [REDACTED]	
3. AGE [REDACTED]		4. DATE OF BIRTH [REDACTED]	
5. PLACE OF BIRTH [REDACTED]		6. OCCUPATION [REDACTED]	
7. MARITAL STATUS [REDACTED]		8. CAUSE OF DEATH [REDACTED]	
9. MANNER OF DEATH [REDACTED]		10. SIGNATURE OF EXAMINER [REDACTED]	
11. SIGNATURE OF WITNESS [REDACTED]		12. SIGNATURE OF CORONER [REDACTED]	
13. SIGNATURE OF JURY [REDACTED]		14. SIGNATURE OF JURY [REDACTED]	
15. SIGNATURE OF JURY [REDACTED]		16. SIGNATURE OF JURY [REDACTED]	
17. SIGNATURE OF JURY [REDACTED]		18. SIGNATURE OF JURY [REDACTED]	
19. SIGNATURE OF JURY [REDACTED]		20. SIGNATURE OF JURY [REDACTED]	
21. SIGNATURE OF JURY [REDACTED]		22. SIGNATURE OF JURY [REDACTED]	
23. SIGNATURE OF JURY [REDACTED]		24. SIGNATURE OF JURY [REDACTED]	
25. SIGNATURE OF JURY [REDACTED]		26. SIGNATURE OF JURY [REDACTED]	
27. SIGNATURE OF JURY [REDACTED]		28. SIGNATURE OF JURY [REDACTED]	
29. SIGNATURE OF JURY [REDACTED]		30. SIGNATURE OF JURY [REDACTED]	
31. SIGNATURE OF JURY [REDACTED]		32. SIGNATURE OF JURY [REDACTED]	
33. SIGNATURE OF JURY [REDACTED]		34. SIGNATURE OF JURY [REDACTED]	
35. SIGNATURE OF JURY [REDACTED]		36. SIGNATURE OF JURY [REDACTED]	
37. SIGNATURE OF JURY [REDACTED]		38. SIGNATURE OF JURY [REDACTED]	
39. SIGNATURE OF JURY [REDACTED]		40. SIGNATURE OF JURY [REDACTED]	
41. SIGNATURE OF JURY [REDACTED]		42. SIGNATURE OF JURY [REDACTED]	
43. SIGNATURE OF JURY [REDACTED]		44. SIGNATURE OF JURY [REDACTED]	
45. SIGNATURE OF JURY [REDACTED]		46. SIGNATURE OF JURY [REDACTED]	
47. SIGNATURE OF JURY [REDACTED]		48. SIGNATURE OF JURY [REDACTED]	
49. SIGNATURE OF JURY [REDACTED]		50. SIGNATURE OF JURY [REDACTED]	
51. SIGNATURE OF JURY [REDACTED]		52. SIGNATURE OF JURY [REDACTED]	
53. SIGNATURE OF JURY [REDACTED]		54. SIGNATURE OF JURY [REDACTED]	
55. SIGNATURE OF JURY [REDACTED]		56. SIGNATURE OF JURY [REDACTED]	
57. SIGNATURE OF JURY [REDACTED]		58. SIGNATURE OF JURY [REDACTED]	
59. SIGNATURE OF JURY [REDACTED]		60. SIGNATURE OF JURY [REDACTED]	
61. SIGNATURE OF JURY [REDACTED]		62. SIGNATURE OF JURY [REDACTED]	
63. SIGNATURE OF JURY [REDACTED]		64. SIGNATURE OF JURY [REDACTED]	
65. SIGNATURE OF JURY [REDACTED]		66. SIGNATURE OF JURY [REDACTED]	
67. SIGNATURE OF JURY [REDACTED]		68. SIGNATURE OF JURY [REDACTED]	
69. SIGNATURE OF JURY [REDACTED]		70. SIGNATURE OF JURY [REDACTED]	
71. SIGNATURE OF JURY [REDACTED]		72. SIGNATURE OF JURY [REDACTED]	
73. SIGNATURE OF JURY [REDACTED]		74. SIGNATURE OF JURY [REDACTED]	
75. SIGNATURE OF JURY [REDACTED]		76. SIGNATURE OF JURY [REDACTED]	
77. SIGNATURE OF JURY [REDACTED]		78. SIGNATURE OF JURY [REDACTED]	
79. SIGNATURE OF JURY [REDACTED]		80. SIGNATURE OF JURY [REDACTED]	
81. SIGNATURE OF JURY [REDACTED]		82. SIGNATURE OF JURY [REDACTED]	
83. SIGNATURE OF JURY [REDACTED]		84. SIGNATURE OF JURY [REDACTED]	
85. SIGNATURE OF JURY [REDACTED]		86. SIGNATURE OF JURY [REDACTED]	
87. SIGNATURE OF JURY [REDACTED]		88. SIGNATURE OF JURY [REDACTED]	
89. SIGNATURE OF JURY [REDACTED]		90. SIGNATURE OF JURY [REDACTED]	
91. SIGNATURE OF JURY [REDACTED]		92. SIGNATURE OF JURY [REDACTED]	
93. SIGNATURE OF JURY [REDACTED]		94. SIGNATURE OF JURY [REDACTED]	
95. SIGNATURE OF JURY [REDACTED]		96. SIGNATURE OF JURY [REDACTED]	
97. SIGNATURE OF JURY [REDACTED]		98. SIGNATURE OF JURY [REDACTED]	
99. SIGNATURE OF JURY [REDACTED]		100. SIGNATURE OF JURY [REDACTED]	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1542

CERTIFICATE OF DEATH

01543

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Raspeburg</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ivy Hall Nursing Home</u>				d. STREET ADDRESS <u>19 Harrison St Baltimore</u> 20			
3. NAME OF DECEASED (Type or print) First <u>Matthew</u> Middle <u>J. O'Brien</u> Last				4. DATE OF DEATH Month <u>February</u> Day <u>19</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 28, 1889</u>		9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chauffeur</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>State Roads</u>		11. BIRTHPLACE (State or foreign country) <u>Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James O'Brien</u>				14. MOTHER'S MAIDEN NAME <u>Ellen Hyland</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs. Christina Huppman Box 305 Gum Spring Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Left Hemislegia</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral thrombosis</u> DUE TO (c) <u>Cerebral arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>10 days</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>azotemia, intoxication due to</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Aug 27</u> , 19 <u>56</u> , to <u>Feb 19</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Feb 16</u> , 19 <u>57</u> , and the death occurred at <u>11 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Harvey L. Fuller</u> M.D.				ADDRESS (Street, city or town, state) <u>Ridge Road</u>		DATE SIGNED <u>Feb 19/57</u>	
PHYSICIAN'S NAME (Type) <u>HARVEY L. FULLER</u>				<u>Baltimore 6 Ind</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-22-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ebenezer Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lassahn Funeral Home</u>				ADDRESS <u>7401 Belair Rd</u>		24a. REC'D BY REGISTRAR <u>Edith Hurler</u> 24b. REGISTRAR'S SIGNATURE	
				DATE <u>FEB 21 1957</u>			

CERTIFICATE OF DEATH

PLACE OF BIRTH		PLACE OF DEATH	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	
DATE OF BIRTH		DATE OF DEATH	
JAN 15 1907		JAN 15 1907	
AGE		AGE	
19		19	
SEX		SEX	
MALE		MALE	
RACE		RACE	
WHITE		WHITE	
OCCUPATION		OCCUPATION	
LABORER		LABORER	
CAUSE OF DEATH		CAUSE OF DEATH	
DIPHTHERIA		DIPHTHERIA	
MANNER OF DEATH		MANNER OF DEATH	
NATURAL		NATURAL	
PLACE OF INTERMENT		PLACE OF INTERMENT	
CATHOLIC CHURCH		CATHOLIC CHURCH	
DATE OF INTERMENT		DATE OF INTERMENT	
JAN 15 1907		JAN 15 1907	
SIGNATURE OF REGISTRAR		SIGNATURE OF REGISTRAR	
J. H. HARRIS		J. H. HARRIS	
OFFICIAL SEAL		OFFICIAL SEAL	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	
JAN 15 1907		JAN 15 1907	

BUREAU V. S.

FEB 21 1907

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4

1543

CERTIFICATE OF DEATH

01544

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 618 Coleraine Rd		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Adelaide Middle C. O'Leary Last		4. DATE OF DEATH Month Feb. Day 3, Year 19 57	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 27, 1888
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		10b. KIND OF BUSINESS OR INDUSTRY O.H.	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Egner		14. MOTHER'S MAIDEN NAME Clara Cook	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 0		16. SOCIAL SECURITY NO. 0	
17. INFORMANT Mr. Dennis D. O'Leary		Address 618 Coleraine Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) GENERALIZED ARTERIO-SCLEROSIS. DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 6 DAYS 1-4 Yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 0		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 0		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 0	
20c. TIME OF INJURY Hour a. 0 p. m. Month 0 Day 19 Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 0		20f. (City or town) (County) (State) 0	
21. I certify that I attended the deceased from JAN. 27 , 19 57 , to FEB. 3 , 19 57 , that I last saw the deceased alive on FEB. 2 , 19 57 , and that death occurred 5:45 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>S. Lloyd Johnson</i>		DATE SIGNED 6348 FREDERICK ROAD. CATONSVILLE	
PHYSICIAN'S NAME (Type) S. LLOYD JOHNSON. M.D.		BALTIMORE 28 MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Feb. 6/57	22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.	22d. LOCATION (City, town, or county) (State) Balto. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Harry H. Witzke,		ADDRESS 4101 Edmondson Ave.	
24a. REC'D BY REGISTRAR FEB 6 '57		24b. REGISTRAR'S SIGNATURE <i>W. Beach</i>	

CERTIFICATE OF DEATH

NAME OF DECEASED JOHN J. JOHNSON		AGE 65		SEX M		RACE W		DATE OF BIRTH JAN 27 1892		PLACE OF BIRTH BALTIMORE, MD	
MARRIAGE MARRIED		EDUCATION HIGH SCHOOL		OCCUPATION LABORER		RELIGION METHODIST		MANNER OF DEATH HEART DISEASE		CAUSE OF DEATH CORONARY ARTERIO-SCLEROSIS	
DATE OF DEATH FEB 2 1957		PLACE OF DEATH HOME		TIME OF DEATH 10:00 AM		TEMPERATURE 100.0		PULSE 100		RESPIRATION 20	
SIGNATURE OF PHYSICIAN S. LLOYD JOHNSON, M.D.		SIGNATURE OF WITNESSES J. J. JOHNSON, JR.		SIGNATURE OF DECEASED JOHN J. JOHNSON		SIGNATURE OF FUNERAL HOME JOHN J. JOHNSON		SIGNATURE OF CLERK JOHN J. JOHNSON		SIGNATURE OF REGISTRAR JOHN J. JOHNSON	

6748 FREDERICK ROAD, BALTIMORE 28, MD
FEB 6 1957
BUREAU V. S.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01545

Reg. Dist. No.

1544

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex			c. LENGTH OF STAY IN 1b 		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 54 Essex, Md.				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1621 Hopewell Ave.				d. STREET ADDRESS 1621 Hopewell Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First DIANE Middle OVERTON Last OVERTON				4. DATE OF DEATH Month February Day 20 Year 19 57					
5. SEX Female		6. COLOR OR RACE Closed		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan 27, 1957			
9. AGE (In years last birthday) yrs. 21		IF UNDER 1 YEAR Months 21		IF UNDER 24 HRS. Hours 21 Min. 57		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant			
10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (State or foreign country) Baltimore Md.			12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Edward Overton				14. MOTHER'S MAIDEN NAME Lecky Brown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 		17. INFORMANT Address Edward Overton 1621 Hopewell Ave.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 763.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Otitis Media DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 								INTERVAL BETWEEN ONSET AND DEATH 	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) (County) (State) 			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE William V. Lovitt, Jr.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 2/20/57			
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.				 					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/23/57		22c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.		22d. LOCATION (City, town, or county) (State) Baltimore Md.			
23. FUNERAL DIRECTOR'S SIGNATURE G. Holstead				ADDRESS 918 Druid Hill Ave.		24a. REC'D BY REGISTRAR DATE FEB 25 1957			
 				24b. REGISTRAR'S SIGNATURE Edith Purdy		 			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

2033203xv5

MARYLAND STATE DEPARTMENT OF HEALTH—Baltimore
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
FEB 25 1957
BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>		c. LENGTH OF STAY IN 1b <i>1 1/2 yrs.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Ridgeway Manor 5743 Edmondson</i>		d. STREET ADDRESS <i>512 Glen Allen Drive.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>William E Owens</i>		4. DATE OF DEATH <i>Feb. 12 1957</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 5, 1865</i>
9. AGE (In years last birthday) <i>91</i> yrs.		IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Plumber</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Self Employed</i>	
11. BIRTHPLACE (State or foreign country) <i>Baltimore Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Frank Owens</i>		14. MOTHER'S MAIDEN NAME <i>Ann Mc Cormick</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, not unknown) <i>NO</i> (If yes, give dates of service)		16. SOCIAL SECURITY NO. <i>NO</i>	
17. INFORMANT <i>Mrs. Clara Nichol</i>		Address <i>1609 Kirkwood Rd. 29</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Peripheral Vas. Insufficiency (gangrene)</i> 450.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerosis</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Cerebral Arteriosclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>4 months</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>July 1949</i> to <i>July 12, 1957</i> , that I last saw the deceased alive on <i>July 4, 1957</i> , and that death occurred at <i>5:10 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Lester A. Wall Jr.</i>		ADDRESS (Street, city or town, state) <i>1039 St. Paul St Baltimore Md 21215</i>	
PHYSICIAN'S NAME (Type) <i>LESTER A. WALL JR</i>		DATE SIGNED <i>2/12/57</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>2/15/57</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Salem Lutheran</i>		22d. LOCATION (City, town, or county) (State) <i>Catonsville Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John T. Stansbury</i>		ADDRESS <i>6411 Windsor Mill Rd.</i>	
24a. REC'D BY REGISTRAR <i>Feb 18 '57</i>		24b. REGISTRAR'S SIGNATURE <i>W. H. Beach</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01547

CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD.</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore 12</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Baltimore (12)</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>513 Murdock Rd.</i>		d. STREET ADDRESS <i>513 Murdock Rd.</i>	
3. NAME OF DECEASED (Type or print) First <i>William</i> Middle <i>A</i> Last <i>PARKER, Sr.</i>		4. DATE OF DEATH Month <i>Feb.</i> Day <i>2</i> Year <i>1957</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan. 19, 1895</i>
9. AGE (In years last birthday) yrs. <i>62</i>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Mechanic Office machines</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Self employed</i>	
11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Harry Parker</i>		14. MOTHER'S MAIDEN NAME <i>Winnie Dickson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Delphine Parker</i>		Address <i>513 Murdock Rd.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma</i> <i>199.9</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Metastasis to Spine + Lungs</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <i>1 1/2 yr.</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. <i>19</i> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>May 10, 1955</i> to <i>Feb 2, 1957</i> , that I last saw the deceased alive on <i>Jan 2, 1957</i> , and that death occurred at <i>5:30 PM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <i>6805 York Rd Baltimore 12 Md</i> <i>2-4-57</i>			
ACTUAL SIGNATURE <i>Laurence C. Post</i>		M.D. <i>6805 York Rd Baltimore 12 Md</i>	
PHYSICIAN'S NAME (Type) <i>LAURENCE C. POST</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Feb. 5, 1957</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. Cook, Inc.</i>		ADDRESS <i>1217 St. Paul St.</i>	
24a. REC'D BY REGISTRAR <i>FEB 6 1957</i>		24b. REGISTRAR'S SIGNATURE <i>Mabel Gray</i>	

CERTIFICATE OF DEATH

DATE OF DEATH		PLACE OF DEATH		MANNER OF DEATH	
FEB 6 1957		BALTIMORE, MD.		NATURAL	
AGE		SEX		RACE	
65		M		W	
BIRTH DATE		BIRTH PLACE		EDUCATION	
JAN 12 1892		BALTIMORE, MD.		HIGH SCHOOL	
OCCUPATION		MARITAL STATUS		RELIGION	
RETIRED		MARRIED		METHODIST	
PREVIOUS ILLNESS		CAUSE OF DEATH		IMMEDIATE CAUSE	
NONE		CORONARY THROMBOSIS		CORONARY THROMBOSIS	
DATE OF EXAMINATION		PLACE OF EXAMINATION		EXAMINER	
FEB 6 1957		BALTIMORE, MD.		J. H. [illegible]	
SIGNATURE OF PHYSICIAN		SIGNATURE OF EXAMINER		OFFICIAL USE	
[illegible]		[illegible]		[illegible]	

Coronary

BUREAU V. S.

FEB 6 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01548

1547

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville - 28</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5 Cedarwood Road</u>		d. STREET ADDRESS <u>5 Cedarwood Road-Catonsville 28, Md</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>S.R.M.</u> Last <u>PARRISH</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>21</u> Year <u>19 57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 15, 1876</u>
9. AGE (In years lost birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Mayo</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Chase</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Miss Irma E. Pugh-5 Cedarwood Rd.-Balto. 28, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO <u>331x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>331x</u> DUE TO (c) <u>331x</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/10</u> , 19 <u>56</u> , to <u>2/21</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2/21</u> , 19 <u>57</u> , and that death occurred at <u>7:45</u> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert A. Reiter</u> M.D. <u>3408 Windsor Ave.</u> DATE SIGNED <u>2/22/57</u>		ADDRESS (Street, city or town, state)	
PHYSICIAN'S NAME (Type) <u>Robert A. Reiter, M.D.</u> <u>Baltimore-16, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>2/25/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hartford, Connecticut</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tucker Sons - North & Pa. Aves.</u> ADDRESS		24a. REC'D BY REGISTRAR <u>25 57</u> DATE	
24b. REGISTRAR'S SIGNATURE <u>Deborah</u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. TIME OF DEATH		10. CAUSE OF DEATH	
11. PLACE OF DEATH		12. NAME OF PHYSICIAN		13. SIGNATURE OF PHYSICIAN		14. NAME OF CORONER		15. SIGNATURE OF CORONER	
16. NAME OF FUNERAL HOME		17. SIGNATURE OF FUNERAL HOME		18. NAME OF MINISTER		19. SIGNATURE OF MINISTER		20. NAME OF CLERGY	
21. SIGNATURE OF CLERGY		22. NAME OF CLERGY		23. SIGNATURE OF CLERGY		24. NAME OF CLERGY		25. SIGNATURE OF CLERGY	
26. NAME OF CLERGY		27. SIGNATURE OF CLERGY		28. NAME OF CLERGY		29. SIGNATURE OF CLERGY		30. NAME OF CLERGY	
31. SIGNATURE OF CLERGY		32. NAME OF CLERGY		33. SIGNATURE OF CLERGY		34. NAME OF CLERGY		35. SIGNATURE OF CLERGY	
36. NAME OF CLERGY		37. SIGNATURE OF CLERGY		38. NAME OF CLERGY		39. SIGNATURE OF CLERGY		40. NAME OF CLERGY	
41. SIGNATURE OF CLERGY		42. NAME OF CLERGY		43. SIGNATURE OF CLERGY		44. NAME OF CLERGY		45. SIGNATURE OF CLERGY	
46. NAME OF CLERGY		47. SIGNATURE OF CLERGY		48. NAME OF CLERGY		49. SIGNATURE OF CLERGY		50. NAME OF CLERGY	
51. SIGNATURE OF CLERGY		52. NAME OF CLERGY		53. SIGNATURE OF CLERGY		54. NAME OF CLERGY		55. SIGNATURE OF CLERGY	
56. NAME OF CLERGY		57. SIGNATURE OF CLERGY		58. NAME OF CLERGY		59. SIGNATURE OF CLERGY		60. NAME OF CLERGY	
61. SIGNATURE OF CLERGY		62. NAME OF CLERGY		63. SIGNATURE OF CLERGY		64. NAME OF CLERGY		65. SIGNATURE OF CLERGY	
66. NAME OF CLERGY		67. SIGNATURE OF CLERGY		68. NAME OF CLERGY		69. SIGNATURE OF CLERGY		70. NAME OF CLERGY	
71. SIGNATURE OF CLERGY		72. NAME OF CLERGY		73. SIGNATURE OF CLERGY		74. NAME OF CLERGY		75. SIGNATURE OF CLERGY	
76. NAME OF CLERGY		77. SIGNATURE OF CLERGY		78. NAME OF CLERGY		79. SIGNATURE OF CLERGY		80. NAME OF CLERGY	
81. SIGNATURE OF CLERGY		82. NAME OF CLERGY		83. SIGNATURE OF CLERGY		84. NAME OF CLERGY		85. SIGNATURE OF CLERGY	
86. NAME OF CLERGY		87. SIGNATURE OF CLERGY		88. NAME OF CLERGY		89. SIGNATURE OF CLERGY		90. NAME OF CLERGY	
91. SIGNATURE OF CLERGY		92. NAME OF CLERGY		93. SIGNATURE OF CLERGY		94. NAME OF CLERGY		95. SIGNATURE OF CLERGY	
96. NAME OF CLERGY		97. SIGNATURE OF CLERGY		98. NAME OF CLERGY		99. SIGNATURE OF CLERGY		100. NAME OF CLERGY	

RECEIVED
FEB 26 1957
BUREAU V. S.

1

CERTIFICATE OF DEATH

1548

Reg. Dist. No. 33

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Baltimore</i>		MARYLAND		STATE <i>MD</i>		COUNTY <i>Balto</i>	
CITY OR TOWN <i>Cockeysville</i>		LENGTH OF STAY (in this place) <i>1 month</i>		CITY OR TOWN <i>xo Upperco</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Matthews Ave</i>				STREET ADDRESS <i>1 Falls Rd</i>			
3. NAME OF DECEASED (Type or Print) <i>Effie May Hale Perego</i>				4. DATE OF DEATH <i>February 4 1957</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widowed</i>		8. DATE OF BIRTH <i>10 May 1882</i>	
9. AGE last birthday <i>74</i> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>		11. BIRTHPLACE (State or foreign country) <i>Balto Co. Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>Elijah Hale</i>				14. MOTHER'S MAIDEN NAME <i>Sa Wheeler</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT & ADDRESS <i>daughter - Mrs. Curtis - Cockeysville</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
163x IMMEDIATE CAUSE (A) <i>Cancer of pleura of left lung</i>						INTERVAL BETWEEN ONSET AND DEATH <i>4 months</i>	
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <i>15 December 1956</i>		19b. MAJOR FINDINGS OF OPERATION <i>mesothelioma of pleura of left lung</i>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>9 Jan 1957</i> , to <i>4 Feb 1957</i> , that I last saw the deceased alive on <i>4 Feb 1957</i> , and that death occurred at <i>9:40 PM</i> , from the causes and on the date stated above.							
SIGNATURE <i>Robert J. Kees</i>				DATE SIGNED <i>4 Feb 1957</i>			
23. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		DATE THEREOF <i>2-7-57</i>		NAME OF CEMETERY OR CREMATORY <i>Forest Baptist</i>		LOCATION (City, town, or county) (State) <i>Balto Co Md</i>	
24. REC'D BY REGISTRAR <i>2-6-57</i>		REGISTRAR'S SIGNATURE <i>Mary B. Eline</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Edw Epton - Hampstead Md</i>			

INSTRUCTIONS

1. **ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. **FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

1957

1. NAME OF DECEASED (PRINT OR TYPE)

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF NEXT OF KIN

15. SIGNATURE OF BURIAL OFFICIAL

16. SIGNATURE OF FUNERAL HOME

17. SIGNATURE OF CEMETERY

18. SIGNATURE OF CHURCH

19. SIGNATURE OF MINISTERS

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242. SIGNATURE OF CHURCH

243. SIGNATURE OF MINISTERS

244. SIGNATURE OF OTHERS

245. SIGNATURE OF DECEASED

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247. SIGNATURE OF BURIAL OFFICIAL

248. SIGNATURE OF FUNERAL HOME

249. SIGNATURE OF CEMETERY

250. SIGNATURE OF CHURCH

251. SIGNATURE OF MINISTERS

252. SIGNATURE OF OTHERS

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01550
31

CERTIFICATE OF DEATH

Reg. Dist. No.

1549

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u> Xo			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6409 Kriel Avenue</u>				d. STREET ADDRESS <u>6409 Kriel Avenue #7</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>F.</u> Last <u>PETZ</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>18</u> Year <u>19 57</u>		5. SEX <u>Male-</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 21, 1880</u>		9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Andrew Petz</u>				14. MOTHER'S MAIDEN NAME <u>Emma Gottschaldt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>----</u>		17. INFORMANT Address <u>Mrs. Alice B. Petz-6409 Kriel Avenue - #7</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE CONGESTIVE HEART FAILURE</u> <u>443 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>PULMONARY EDEMA + RENAL FAILURE</u> DUE TO (c) <u>HYPERTENSIVE C.V. DISEASE -</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>10 YEARS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JUNE</u> , 19 <u>48</u> , to <u>FEB-18</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>FEB 18</u> , 19 <u>57</u> , and that death occurred at <u>6 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomas E. Wheeler</u>		M.D.		ADDRESS (Street, city or town, state) <u>3601 Cypress Rd -</u>		DATE SIGNED <u>2/20/57</u>	
PHYSICIAN'S NAME (Type) <u>THOMAS E. WHEELER</u>				<u>Balto - Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>2/21/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Landon Park Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm J. Tickner & Sons - North & Pa Ave</u>				24a. REC'D BY REGISTRAR DATE <u>2-20-57</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. Wm. E. Martin</u>	

CERTIFICATE OF DEATH

Reg. Dist. No.

45

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COLGATE				c. LENGTH OF STAY IN 1b XO COLGATE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 402 S. 51ST ST.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First PETER Middle POSINSKI Last				4. DATE OF DEATH Month FEB. Day 26 Year 1957.			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 27, 1887	
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED				10b. KIND OF BUSINESS OR INDUSTRY MOULDER		11. BIRTHPLACE (State or foreign country) GERMANY	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME ADALBERT POSINSKI				14. MOTHER'S MAIDEN NAME MICHAELINE NOVAK			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. 213-01-5180		17. INFORMANT STELLA POSINSKI Address SAME	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIO SCLEROTIC C.V. DISEASE 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ILEOSTOMY DUE TO TUBERCULOUS ABSCESS - 1943							
INTERVAL BETWEEN ONSET AND DEATH 1 MO							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from Feb 12 , 19 57 , to Feb 26 , 19 57 , that I last saw the deceased alive on Feb 25 , 19 57 , and that death occurred at 7:40 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Stephen C. Mackowiak M.D.				ADDRESS (Street, city or town, state) 6714 Holabird Ave			
DATE SIGNED							
PHYSICIAN'S NAME (Type) S. C. MACKOWIAK							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3-2-57.		22c. NAME OF CEMETERY OR CREMATORY ST. STANISLAUS CEM.		22d. LOCATION (City, town, or county) (State) 1300 DUNDALK AVE. BALTO, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles S. Geiler				ADDRESS 9015 CONKLING ST. BALTO, MD.		24a. REC'D BY REGISTRAR DATE 2-27-57	
24b. REGISTRAR'S SIGNATURE Edith Hurley							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Form with multiple fields for death certificate information, including name, date, and location. The text is mirrored and difficult to read.

BUREAU V. S.

FEB 22 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1551

CERTIFICATE OF DEATH

01552

Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 24 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JOHN First W. Middle PRICE Last				4. DATE OF DEATH February Month 11 Day 19 Year 57			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH December 9, 1887	
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Somerset County, Maryland				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		(If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md. Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SUBARACHNOID HEMORRHAGE DUE TO HYPERTENSIVE CARDIOVASCULAR DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) UNKNOWN (c)						INTERVAL BETWEEN ONSET AND DEATH 3 WEEKS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.				20d. INJURY OCCURRED VA While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from January 18, 1957 , to February 11, 1957 , and that death occurred at 7:30 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Irving Freeman M.D.				ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND			
DATE SIGNED 2/13/57							
PHYSICIAN'S NAME (Type) IRVING FREEMAN, M.D., Chief, Medical Service, VAH, Fort Howard, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 16, 1957		22c. NAME OF CEMETERY OR CREMATORY Revell Neck Cemetery		22d. LOCATION (City, town, or county) (State) Princess Anne, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law Mortuary, 802-04 Madison Ave., Balt				ADDRESS 1, Md.		24a. REC'D BY REGISTRAR Feb 15-57	
				24b. REGISTRAR'S SIGNATURE Dawson L. Farber			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Manner of Death		Occupation		Signature of Physician		Signature of Registrar	
John A. Smith		Male		45		January 1, 1912		Baltimore, Md.		Baltimore, Md.		Heart Disease		Natural		Teacher		J. A. Smith		J. A. Smith	
Date of Death		Time of Death		Place of Death		Usual Residence		Cause of Death		Manner of Death		Occupation		Signature of Physician		Signature of Registrar		Date of Report		Place of Report	
February 1, 1957		10:30 A.M.		Baltimore, Md.		Baltimore, Md.		Heart Disease		Natural		Teacher		J. A. Smith		J. A. Smith		February 1, 1957		Baltimore, Md.	
Name of Informant		Relationship		Address		City		State		Zip		Signature of Informant		Date of Report		Place of Report		Signature of Registrar		Date of Report	
John A. Smith		Son		1234 Main St.		Baltimore		Md.		21201		J. A. Smith		February 1, 1957		Baltimore, Md.		J. A. Smith		February 1, 1957	

BUREAU V. S.

FEB 19 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01553

Reg. Dist. No.

38

1552

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Towson			c. LENGTH OF STAY IN 1b ? days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 53 Dundalk	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Woods nr. Loch Raven Dam				d. STREET ADDRESS 2919 Dummery Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM STIRLING PRICE, SR.				4. DATE OF DEATH Month Day Year February 20 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 9. 1893	
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel charger - Beth. Steel Co.				10b. KIND OF BUSINESS OR INDUSTRY Annabois Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harry Price				14. MOTHER'S MAIDEN NAME Susie ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) yes		16. SOCIAL SECURITY NO. W.W. II 216-09-5567		17. INFORMANT (Address) Mrs. Beulah V. Price (Wife) 4006 Lyndale Ave. 13			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot Wound of Head 976X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot self in head.					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Woods		20f. (City or town) (County) (State) nr. Towson Baltimore Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>William V. Levitt, Jr.</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) William V. Levitt, Jr., M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 25. 1957		22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem. Baltimore Md.		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS, INC.				24a. REC'D BY REGISTRAR FEB 25 1957			
24b. REGISTRAR'S SIGNATURE <i>Mabel Grays</i>							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES J. JONES		45		M		W		1912		NEW YORK	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH	
123 Main St., Boston		Carpenter		Heart Disease		Natural		Feb 20, 1957		Boston	
Physician's Name		Hospital		Burial Place		Burial Date		Burial Time		Burial Place	
Dr. J. A. Smith		St. Mary's		Catholic		Feb 22, 1957		10:00 AM		St. Mary's	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Burial Officer		Signature of Undertaker		Signature of Witness	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. S.

FEB 25 1957

RECEIVED

1553

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 90 Wayne Aged & Convalescent Home		d. STREET ADDRESS 1436 North Rolling Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EMMA Middle P. Last PURCELL		4. DATE OF DEATH Month Feb. Day 19th Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 12" 1870
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Alexander Carns		14. MOTHER'S MAIDEN NAME Emma Fisher	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-10-9204	
17. INFORMANT B-George C. Purcell		1436 N. Rolling Road Catonsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardio-Vascular Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 10 yrs.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January , 19 55 , to Feb. 19-57 , 19 57 , that I last saw the deceased alive on Feb. 19 , 19 57 , and that death occurred at 2 P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Marvin Goldstein M.D. February, 20th 1957			
ACTUAL SIGNATURE Marvin Goldstein		PHYSICIAN'S NAME (Type) Marvin Goldstein	
5334 Liberty Heights Avenue			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 23" 1957	
22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		22d. LOCATION (City, town, or county) (State) Woodlawn Balto. Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Miller Lamoreaux		24a. RECORD BY REGISTRAR W. K. Ketch	
4500 Liberty Heights Avenue		24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

BUREAU V. 3

FEB 25 1957

RECEIVED

1433

CERTIFICATE OF DEATH

Reg. Dist. No.

41

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK 53</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>204 PINEWOOD ROAD, BALTIMORE 22</u>				d. STREET ADDRESS <u>204 PINEWOOD ROAD BALTIMORE</u>			
3. NAME OF DECEASED (Type or print) First <u>LOUISE</u> Middle <u>L.</u> Last <u>REHILL</u>				4. DATE OF DEATH Month <u>2</u> Day <u>11</u> Year <u>1957</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCTOBER 27, 1889</u>	9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>WISCONSIN</u>	
13. FATHER'S NAME <u>JULIUS LIEBIG</u>				14. MOTHER'S MAIDEN NAME <u>MINNA GOTTESLEBEN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>Balt 22</u> <u>Miss Louise Irene Rehill 204 Pinewood Road Dundalk Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>arteriosclerotic heart disease</u> 2 years DUE TO (c) <u>Generalized arteriosclerosis</u> 10 years							INTERVAL BETWEEN ONSET AND DEATH <u>3-4 hr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Sept</u> , 19 <u>55</u> , to <u>2-11</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2-11</u> , 19 <u>57</u> , and that death occurred at <u>7:50 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Eugene F Nevy</u> M.D.				ADDRESS (Street, city or town, state) <u>7001 Morningside Rd</u>			
PHYSICIAN'S NAME (Type) <u>Eugene F Nevy</u>				DATE SIGNED <u>Dundalk 22, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2-13-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>METHODIST</u>		22d. LOCATION (City, town, or county) (State) <u>NORTH EAST, Cecil, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R Grant</u>				ADDRESS <u>North East Md</u>		24a. REC'D BY REGISTRAR DATE <u>13 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>John Kelly</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 1554
 CERTIFICATE OF DEATH

01556

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto Co</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>611 Ingleside Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ESTHER O REICH</u> First Middle Last		4. DATE OF DEATH <u>2/28/57</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/20/91</u>
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Shipley</u>		14. MOTHER'S MAIDEN NAME <u>Alice Elgin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>1</u>	
17. INFORMANT <u>Samuel Reich</u> Address <u>(same)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1 Congestive Heart Failure</u> DUE TO (b) <u>Pulmonic infarct</u> DUE TO (c) <u>Cardio-vascular disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 Mon.</u> <u>5 Mon.</u> <u>15 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-9-</u> , 19 <u>41</u> , to <u>2-28-</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2-28</u> , 19 <u>57</u> , and that death occurred at <u>1:46</u> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>203-Ingleside Ave., Balto.</u> DATE SIGNED <u>28-3-2-57</u>			
ACTUAL SIGNATURE <u>R. M. Hening</u>		M.D. <u>203-Ingleside Ave., Balto.</u>	
PHYSICIAN'S NAME (Type) <u>Robert M. Hening M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/4/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Torrance</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Co.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mr. Habb + Son</u> ADDRESS <u>28</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 5 '57</u>	
		24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1951

Page One

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		DATE OF BIRTH	
OCCUPATION		SEX	
EDUCATION		RACE	
MARRIAGE		RELIGION	
CAUSE OF DEATH		MANNER OF DEATH	
IMMEDIATE CAUSE		INTERMEDIATE CAUSE	
FUNDAMENTAL CAUSE		PRE-EXISTING DISEASES	
SIGNS AND SYMPTOMS		TREATMENT	
HISTORY		FAMILY HISTORY	
SOCIAL HISTORY		PERSONAL HISTORY	
PHYSICAL EXAMINATION		LABORATORY EXAMINATIONS	
PATHOLOGICAL FINDINGS		MICROSCOPIC FINDINGS	
GROSS FINDINGS		HISTOLOGIC FINDINGS	
IMPRESSION		REMARKS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE		DATE	

BUREAU V. S.

MAR 5 1951

RECEIVED

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01557

1438

CERTIFICATE OF DEATH

Reg. Dist. No.

47

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Relay		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Relay	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1603 Rolling Rd		d. STREET ADDRESS 1603 Rolling Rd.	
3. NAME OF DECEASED (Type or print) First Middle Last Marguerite W. Reynolds		4. DATE OF DEATH Month Day Year Feb. 16 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 18, 1896
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		10b. KIND OF BUSINESS OR INDUSTRY O.H.	11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME R. Brent Walling	
14. MOTHER'S MAIDEN NAME Margaret E. Woodward		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. Mr. N. Edmundson, Reynolds, 1603 Rolling Rd		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Splenic Leukemia 204.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diffuse Hemorrhage 2 wks DUE TO (c) Myocarditis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1 yr INTERVAL BETWEEN ONSET AND DEATH 1 mo			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 2, 1926 , to Feb. 16 19 57 , that I last saw the deceased alive on Feb 15 19 57 , and that death occurred at 8 30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE B B Brumback M.D.		ADDRESS (Street, city or town, state) 609 Main St Edsbridge	
PHYSICIAN'S NAME (Type) B B Brumback		DATE SIGNED 2-19-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Feb. 20/57	22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.	22d. LOCATION (City, town, or county) (State) Balto. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Harry H. Witzke, 4101 Edmondson Ave.		24a. REC'D BY REGISTRAR Feb 20 1957	
ADDRESS		24b. REGISTRAR'S SIGNATURE Dr. Geo M. Kuffner	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01558

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 5yr10mth26days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		3. DATE OF DEATH Month Feb. Day 26, Year 19 57	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
4. NAME OF DECEASED (Type or print) First Grace Middle Rogers Last Rogers		5. DATE OF DEATH Month Feb. Day 26, Year 19 57	
6. SEX female	7. COLOR OR RACE white	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. DATE OF BIRTH 1872 Aug. 28
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME W. H. Rogers		14. MOTHER'S MAIDEN NAME Emma	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac failure 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) metastatic carcinoma, breast, (post-operative) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 25 , 19 57 , to 2-26- , 19 57 , that I last saw the deceased alive on 2-26- , 19 57 , and that death occurred at 1:45 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED ACTUAL SIGNATURE David E. Edwards M.D. PHYSICIAN'S NAME (Type) DAVID E. EDWARDS CATONSVILLE 28, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 27, 1957	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons Inc. 1900 Eutaw Place		24a. REC'D BY REGISTRAR FEB 27 '57	
24b. REGISTRAR'S SIGNATURE W. H. Edwards			

BUREAU V. B.

FEB 27 1957

RECEIVED

2411 N. Charles Street, Baltimore

1556 CERTIFICATE OF DEATH

Reg. Dist. No. 30.....

1. PLACE OF DEATH COUNTY Baltimore Catonsville,		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Md COUNTY Harford	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN From April 1956 to date		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Harford	
HOSPITAL OR INSTITUTION OR STREET ADDRESS House In The Pines		STREET ADDRESS (If rural, give location) 16 Fasting Avenue	
3. NAME OF DECEASED (First) (Middle) (Last) John Franklin Ross		4. DATE OF DEATH (Month) (Day) (Year) Feb. 6 1957	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH 8/15/1913
9. AGE last birthday 41 yrs.		10. AGE last birthday If under 1 year Months Days If under 24 hrs Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Jockey		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Bel Air		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME David H Ross		14. MOTHER'S MAIDEN NAME Sally Leon	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS Wm. Nelson, 1017 N. 1st St., Baltimore, Md.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH										INTERVAL BETWEEN ONSET AND DEATH	
154x Immediate cause (a) Carcinoma of rectum Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) (c)											
II. OTHER SIGNIFICANT CONDITIONS											
Conditions contributing to the death but not related to the disease or condition causing death.											
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY?	
										Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT		(Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY)		(STATE)	
SUICIDE				INJURY							
HOMICIDE											
TIME (Month)		(Day)		(Year)		(Hour)		INJURY OCCURRED		HOW DID INJURY OCCUR?	
OF								While at			
INJURY						m.		Work <input type="checkbox"/>		At work <input type="checkbox"/>	

22. I hereby certify that I attended the deceased from July 2, 1956, to Feb. 6, 1957, that I last saw the deceased alive on Feb. 5, 1957, and that death occurred at 11:15 A.m., from the causes and on the date stated above.

SIGNATURE _____ (Degree or title) ADDRESS _____ DATE SIGNED _____

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Feb 7 / 1957	Not Given Cemetery	Belair Hundred Co MD	Rural
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
FEB 13 57	Overman	Joseph H. Foster	Belair Md	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

BUREAU V. S.

FEB 14 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01560

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1557 Item 7 FilmG211 3-1-57 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 5mths29dys	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 333S. Bentalou St.	
3. NAME OF DECEASED (Type or print) First Caroline Middle Rothman Last Rothman		4. DATE OF DEATH Month February Day 22 Year 19 57	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 11, 1875
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME unknown Samuel W Richardson		14. MOTHER'S MAIDEN NAME unknown Sarah Pancost	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute cardiac failure DUE TO (b) Cardio Vascular disease Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. Sept. 11, 1875 fracture right hip - Smith Peterson nail + plate PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) fracture right hip - Smith Peterson nail + plate			
INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pt. fell to floor on 1-29-57 while getting out of bed; sustaining a frac. right hip.	
20c. TIME OF INJURY Month, Day, Year 1-29-57 Hour 3:05 o. m. PM		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital		20f. (City or town) (County) (State) Catonsville 28, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Geo M Kieffer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) George M. Kieffer, M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-26-1957	
22c. NAME OF CEMETERY OR CREMATORY Catholic National		22d. LOCATION (City, town, or county) (State) Baltimore Md	
23. FUNERAL DIRECTOR'S SIGNATURE John B. M. Walters		ADDRESS Pratt & Smith	
24a. REC'D BY REGISTRAR 1957 25 57		24b. REGISTRAR'S SIGNATURE Quinn	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED [REDACTED]		SEX [REDACTED]		AGE [REDACTED]	
PLACE OF BIRTH [REDACTED]		DATE OF BIRTH [REDACTED]		TIME OF BIRTH [REDACTED]	
OCCUPATION [REDACTED]		CAUSE OF DEATH [REDACTED]		MANNER OF DEATH [REDACTED]	
PLACE OF DEATH [REDACTED]		DATE OF DEATH [REDACTED]		TIME OF DEATH [REDACTED]	
SIGNATURE OF EXAMINER [REDACTED]		SIGNATURE OF WITNESS [REDACTED]		SIGNATURE OF CORONER [REDACTED]	
CERTIFICATE NO. [REDACTED]		COUNTY [REDACTED]		CITY [REDACTED]	

RECEIVED
 FEB 06 1957
 BUREAU V. 3

1

INSTRUCTIONS

TO **ENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The information copy may be retained by the hospital or attending physician.

TO **FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01561

1439 CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH COUNTY <u>BALTIMORE</u> MARYLAND CITY OR TOWN <u>BALTO Highlands</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7901 DELAWARE AVE</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md</u> COUNTY <u>BALTO</u> CITY OR TOWN <u>BALTO Highlands</u> STREET ADDRESS <u>7901 DELAWARE AVE</u>	
3. NAME OF DECEASED (Type or Print) <u>IRENE</u> (First) <u>RUSSELL</u> (Last)		4. DATE OF DEATH (Month) <u>Feb</u> (Day) <u>4</u> (Year) <u>1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>JULY 25-1876</u>
9. AGE last birthday <u>80</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AW</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BALTO Md</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTO Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>WILLIAM WILLIAMS</u>		14. MOTHER'S MAIDEN NAME <u> </u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NO NE</u>	
17. INFORMANT & ADDRESS <u>Virginia M. KESNER 7901 DELAWARE AVE</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 331X IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized Arteriosclerosis</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>10 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> Not while at work <input type="checkbox"/> While at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>July 11, 1956</u> , to <u>Feb 4, 1957</u> , that I last saw the deceased alive on <u>Feb 2, 1957</u> , and that death occurred at <u>11:45 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Paul Schufeldt</u> M.D.		ADDRESS (Street, city, town, state) <u>3301 Arundel St BALTO Md</u>	
DATE SIGNED <u>2/5/57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>FEB 7-1957</u>	
NAME OF CEMETERY OR CREMATORY <u>Mt Olivet Cem</u>		LOCATION (City, town, or county) (State) <u>BALTO Md</u>	
24. REC'D BY REGISTRAR <u>FEB 8 1957</u>		REGISTRAR'S SIGNATURE <u>Dr. J. M. Kuffner</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. C. B. M. Walters</u>		ADDRESS <u>Pratt St</u>	

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

BUREAU V. S.

FEB 6 1957

RECEIVED

RECEIVED

1558

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <input checked="" type="checkbox"/> o. STATE <u>Maryland</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>				c. LENGTH OF STAY IN 1b <u>7 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove State Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MATTHEW ALBERT RUTTER</u>				4. DATE OF DEATH Month Day Year <u>February 2 1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/7/1883</u>	9. AGE (In years lost birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>U.S. MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>by birth.</u>	
13. FATHER'S NAME <u>EDWARD RUTTER</u>				14. MOTHER'S MAIDEN NAME <u>CATHERINE LYNCH</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hospital record</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral pulmonary infarction and thrombosis</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 25, 1957</u> , to <u>Feb 2, 1957</u> , that I last saw the deceased alive on <u>Feb 2, 1957</u> , and that death occurred at <u>11:35 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stella Wachler</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>SPRING GROVE STATE HOSPITAL 2-4-57</u>			
PHYSICIAN'S NAME (Type) <u>Stella Wachler, M. D.</u>				Catonsville 28, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>FEB. 6, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CATHEDRAL CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>E. Vernon Summer</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 5 '57</u>		24b. REGISTRAR'S SIGNATURE <u>Webb</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>	
3. AGE <i>45</i>		4. DATE OF BIRTH <i>Jan 15 1912</i>	
5. PLACE OF BIRTH <i>Baltimore, Md.</i>		6. OCCUPATION <i>Teacher</i>	
7. MARITAL STATUS <i>Married</i>		8. NAME OF SPOUSE <i>Jane Doe</i>	
9. PLACE OF DEATH <i>Home</i>		10. CAUSE OF DEATH <i>Heart Disease</i>	
11. TIME OF DEATH <i>10:15 AM</i>		12. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>	
13. SIGNATURE OF WITNESS <i>John Doe</i>		14. SIGNATURE OF DECEASED <i>John Doe</i>	
15. SIGNATURE OF FUNERAL HOME <i>ABC Funeral Home</i>		16. SIGNATURE OF REGISTRAR <i>John Doe</i>	
17. SIGNATURE OF CLERK <i>John Doe</i>		18. SIGNATURE OF CHIEF CLERK <i>John Doe</i>	
19. SIGNATURE OF ASSISTANT CLERK <i>John Doe</i>		20. SIGNATURE OF DEPUTY CLERK <i>John Doe</i>	
21. SIGNATURE OF CLERK <i>John Doe</i>		22. SIGNATURE OF CLERK <i>John Doe</i>	
23. SIGNATURE OF CLERK <i>John Doe</i>		24. SIGNATURE OF CLERK <i>John Doe</i>	
25. SIGNATURE OF CLERK <i>John Doe</i>		26. SIGNATURE OF CLERK <i>John Doe</i>	
27. SIGNATURE OF CLERK <i>John Doe</i>		28. SIGNATURE OF CLERK <i>John Doe</i>	
29. SIGNATURE OF CLERK <i>John Doe</i>		30. SIGNATURE OF CLERK <i>John Doe</i>	
31. SIGNATURE OF CLERK <i>John Doe</i>		32. SIGNATURE OF CLERK <i>John Doe</i>	
33. SIGNATURE OF CLERK <i>John Doe</i>		34. SIGNATURE OF CLERK <i>John Doe</i>	
35. SIGNATURE OF CLERK <i>John Doe</i>		36. SIGNATURE OF CLERK <i>John Doe</i>	
37. SIGNATURE OF CLERK <i>John Doe</i>		38. SIGNATURE OF CLERK <i>John Doe</i>	
39. SIGNATURE OF CLERK <i>John Doe</i>		40. SIGNATURE OF CLERK <i>John Doe</i>	
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45. SIGNATURE OF CLERK <i>John Doe</i>		46. SIGNATURE OF CLERK <i>John Doe</i>	
47. SIGNATURE OF CLERK <i>John Doe</i>		48. SIGNATURE OF CLERK <i>John Doe</i>	
49. SIGNATURE OF CLERK <i>John Doe</i>		50. SIGNATURE OF CLERK <i>John Doe</i>	
51. SIGNATURE OF CLERK <i>John Doe</i>		52. SIGNATURE OF CLERK <i>John Doe</i>	
53. SIGNATURE OF CLERK <i>John Doe</i>		54. SIGNATURE OF CLERK <i>John Doe</i>	
55. SIGNATURE OF CLERK <i>John Doe</i>		56. SIGNATURE OF CLERK <i>John Doe</i>	
57. SIGNATURE OF CLERK <i>John Doe</i>		58. SIGNATURE OF CLERK <i>John Doe</i>	
59. SIGNATURE OF CLERK <i>John Doe</i>		60. SIGNATURE OF CLERK <i>John Doe</i>	
61. SIGNATURE OF CLERK <i>John Doe</i>		62. SIGNATURE OF CLERK <i>John Doe</i>	
63. SIGNATURE OF CLERK <i>John Doe</i>		64. SIGNATURE OF CLERK <i>John Doe</i>	
65. SIGNATURE OF CLERK <i>John Doe</i>		66. SIGNATURE OF CLERK <i>John Doe</i>	
67. SIGNATURE OF CLERK <i>John Doe</i>		68. SIGNATURE OF CLERK <i>John Doe</i>	
69. SIGNATURE OF CLERK <i>John Doe</i>		70. SIGNATURE OF CLERK <i>John Doe</i>	
71. SIGNATURE OF CLERK <i>John Doe</i>		72. SIGNATURE OF CLERK <i>John Doe</i>	
73. SIGNATURE OF CLERK <i>John Doe</i>		74. SIGNATURE OF CLERK <i>John Doe</i>	
75. SIGNATURE OF CLERK <i>John Doe</i>		76. SIGNATURE OF CLERK <i>John Doe</i>	
77. SIGNATURE OF CLERK <i>John Doe</i>		78. SIGNATURE OF CLERK <i>John Doe</i>	
79. SIGNATURE OF CLERK <i>John Doe</i>		80. SIGNATURE OF CLERK <i>John Doe</i>	
81. SIGNATURE OF CLERK <i>John Doe</i>		82. SIGNATURE OF CLERK <i>John Doe</i>	
83. SIGNATURE OF CLERK <i>John Doe</i>		84. SIGNATURE OF CLERK <i>John Doe</i>	
85. SIGNATURE OF CLERK <i>John Doe</i>		86. SIGNATURE OF CLERK <i>John Doe</i>	
87. SIGNATURE OF CLERK <i>John Doe</i>		88. SIGNATURE OF CLERK <i>John Doe</i>	
89. SIGNATURE OF CLERK <i>John Doe</i>		90. SIGNATURE OF CLERK <i>John Doe</i>	
91. SIGNATURE OF CLERK <i>John Doe</i>		92. SIGNATURE OF CLERK <i>John Doe</i>	
93. SIGNATURE OF CLERK <i>John Doe</i>		94. SIGNATURE OF CLERK <i>John Doe</i>	
95. SIGNATURE OF CLERK <i>John Doe</i>		96. SIGNATURE OF CLERK <i>John Doe</i>	
97. SIGNATURE OF CLERK <i>John Doe</i>		98. SIGNATURE OF CLERK <i>John Doe</i>	
99. SIGNATURE OF CLERK <i>John Doe</i>		100. SIGNATURE OF CLERK <i>John Doe</i>	

RECEIVED
FEB 5 1957
BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. The uniform copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A19C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01563

1434 CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH COUNTY <u>BALTO.</u> MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>DUNDALK 22</u> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1911 PENHALL RD.</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md</u> COUNTY <u>BALTO</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK 22</u> TOWN STREET ADDRESS (If rural give location) <u>1911 PENHALL RD.</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>GENEVIEVE LEE SANDRIDGE</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>2-17-1957</u>			
5. SEX <u>FEM.</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>MAR. 2. 1913</u>	9. AGE last birthday <u>43</u> yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>COOK WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>W. VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ITMES F. SEARS</u>				14. MOTHER'S MAIDEN NAME <u>NORA R. LYNCH</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>J. L. SANDRIDGE - SAME</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 171X IMMEDIATE CAUSE (A) <u>CA of Cervix</u> ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO (C)				18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1-15</u> , 19 <u>57</u> , to <u>2-17</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2-16</u> , 19 <u>57</u> , and that death occurred at <u>7:10 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>James P. Callan</u>		M.D. <u>2165 N. York Blvd 22</u>		DATE SIGNED <u>2-18-57</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	DATE THEREOF <u>2/20/57</u>	NAME OF CEMETERY OR CREMATORY <u>COOK SPRINGS</u>		LOCATION (City, town, or county) (State) <u>WEBSTER SPRINGS W. VA</u>			
24. REC'D BY REGISTRAR <u>B 20 1957</u>	REGISTRAR'S SIGNATURE <u>Jim Kelly</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Brink-Bondy, Dundalk, Md.</u>					

CERTIFICATE OF DEATH

Reg. No. 105

1. Name of deceased (Print or write)

John A. Smith

2. Sex (M or F)

Male

3. Date of birth (Month, day, year)

Jan 15, 1915

4. Place of birth (City, State, Country)

Baltimore, Md.

5. Usual residence (City, State, Country)

Baltimore, Md.

6. Cause of death (State briefly)

Heart disease

7. Immediate cause of death (State briefly)

Myocardial infarction

8. Duration of illness (State briefly)

Several days

9. Date of death (Month, day, year)

Feb 10, 1957

10. Signature of physician (Print name)

John A. Smith

11. Signature of registrar (Print name)

John A. Smith

12. Signature of physician (Print name)

John A. Smith

13. Signature of registrar (Print name)

John A. Smith

14. Signature of physician (Print name)

John A. Smith

15. Signature of registrar (Print name)

John A. Smith

16. Signature of physician (Print name)

John A. Smith

17. Signature of registrar (Print name)

John A. Smith

18. Signature of physician (Print name)

John A. Smith

19. Signature of registrar (Print name)

John A. Smith

20. Signature of physician (Print name)

John A. Smith

21. Signature of registrar (Print name)

John A. Smith

22. Signature of physician (Print name)

John A. Smith

BUREAU A. B.

FEB 20 1957

RECEIVED

INSTRUCTIONS

1559

CERTIFICATE OF DEATH

Reg. Dist. No. 45

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>808 Myrth Ave.</u>				d. STREET ADDRESS <u>808 Myrth Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Annie Sauer</u>				4. DATE OF DEATH Month Day Year <u>February 5, 19 57</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>September 16, 1869</u>		9. AGE (In years last birthday) <u>87</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grocery</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Adam Kuhn</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Micheal Sauer</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Atherosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2</u> years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 3, 1955</u> to <u>Feb 5, 1957</u> that I last saw the deceased alive on <u>Feb 4, 1956</u> , and that death occurred at <u>9 15 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert J. Lyden</u>				ADDRESS (Street, city or town, state) <u>815 Eastern Ave</u>		DATE SIGNED <u>2/6/57</u>	
PHYSICIAN'S NAME (Type) <u>ROBERT J. LYDEN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/8/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James J. Brudzinski</u>				ADDRESS <u>L407 Eastern Ave.</u>		24a. REC'D BY REGISTRAR DATE <u>2/10/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Frank Hurley</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

47

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION		6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. PLACE OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN		13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF DECEASED	

1560

CERTIFICATE OF DEATH

Reg. Dist. No. 45

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MIDDLE RIVER 20</u>				c. LENGTH OF STAY IN 1b <u>4 DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>IVY HALL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ARTHUR</u> Middle <u>L.</u> Last <u>SAYWELL</u>				4. DATE OF DEATH Month <u>2</u> Day <u>6</u> Year <u>1957</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>AUG 31, 1973</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>		IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>RAILROAD</u>		11. BIRTHPLACE (State or foreign country) <u>N. J.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>							
13. FATHER'S NAME <u>WM. R. SAYWELL</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH MACNEILL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>717-09-8326</u>			
17. INFORMANT <u>MRS. BYRON S. SCHWARTZ - SAME</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> 181X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of bladder</u> DUE TO (c) <u>1 year</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>2/3</u> , 19 <u>57</u> , to <u>2/6</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2/5</u> , 19 <u>57</u> , and that death occurred at <u>9 P.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. L. Kolodny MD</u> M.D.				ADDRESS (Street, city or town, state) <u>1725 Eastern Blvd Baltimore 21, MD</u>			
DATE SIGNED <u>2/6/57</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>2-9-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MEADOWVIEW CEM.</u>	
22d. LOCATION (City, town, or county) (State) <u>AMHERST, N. H.</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Pinkie Roddy, 11 Dundalk, MD</u>				24a. REC'D BY REGISTRAR <u>FEB 8 1957</u>			
24b. REGISTRAR'S SIGNATURE <u>Edith Hurley</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4.

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1957

RECEIVED
FEB 9 1957
BUREAU V. S.

<p>1. NAME OF DECEASED JOHN A. SMITH</p>		<p>2. SEX M</p>	
<p>3. AGE 45</p>		<p>4. DATE OF BIRTH 1912</p>	
<p>5. PLACE OF BIRTH NEW YORK</p>		<p>6. OCCUPATION DRIVER</p>	
<p>7. MARITAL STATUS MARRIED</p>		<p>8. DATE OF MARRIAGE 1935</p>	
<p>9. NAME OF SPOUSE MARY J. SMITH</p>		<p>10. DATE OF DEATH FEB 8 1957</p>	
<p>11. PLACE OF DEATH NEW YORK</p>		<p>12. CAUSE OF DEATH HEART DISEASE</p>	
<p>13. MEDICAL HISTORY NO</p>		<p>14. ALCOHOLIC HISTORY NO</p>	
<p>15. TOBACCO HISTORY NO</p>		<p>16. OTHER HISTORY NO</p>	
<p>17. SIGNATURE OF DECEASED JOHN A. SMITH</p>		<p>18. SIGNATURE OF SPOUSE MARY J. SMITH</p>	
<p>19. SIGNATURE OF PHYSICIAN DR. J. H. SMITH</p>		<p>20. SIGNATURE OF REGISTRAR JOHN A. SMITH</p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with
the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1561

CERTIFICATE OF DEATH

01566

Reg. Dist. No.

45

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>AT Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>BERNARD J. Schenning SR.</u>				4. DATE OF DEATH Month Day Year <u>2 - 20 19 57</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-27-1905</u> 51 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TRUCK-OPERATOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BALTO. Co.</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>HENRY Schenning</u>				14. MOTHER'S MAIDEN NAME <u>FUNK</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>216-01-4752</u>		17. INFORMANT <u>EMMA (WIFE)</u> Address <u>SAME</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary arteriosclerosis</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 18, 19 57</u> to <u>Jan 25, 19 57</u> , that I last saw the deceased alive on <u>Jan 25, 19 57</u> , and that death occurred at <u>4 AM</u> from the causes and on the date stated above.				ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>E. A. Flanagan Jr.</u> M.D.				<u>3501 FAIR AVE</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2-23-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>SACRED-HEART</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Connelly, Essex - Md.</u> ADDRESS				24a. REC'D BY REGISTRAR <u>DATE FEB 25 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Edith Hurley</u>	

BUREAU V. S.

FEB 25 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M-

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01567

Item 2 Film 210 2-11-57 ams

CERTIFICATE OF DEATH

1562

Reg. Dist. No. 38

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		LENGTH OF STAY (in this place) <u>Approx. 2 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Stella Maris Hospice</u>		STREET ADDRESS <u>3629 Wilkens Ave.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Dulaney Valley Rd.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Emilia</u> (Middle) <u>Caroline</u> (Last) <u>Schulz</u>				(Month) <u>Feb.</u> (Day) <u>1</u> (Year) <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W</u>	8. DATE OF BIRTH <u>Oct. 21, 1875</u>	9. AGE last birthday <u>82</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>known to none</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Henry Imwold</u>				14. MOTHER'S MAIDEN NAME <u>Anna Kaiser</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>unk.</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mrs. C. E. Berndt - 206 E. Lake Ave.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
181X IMMEDIATE CAUSE (A) <u>Carcinoma of Bladder</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive Cardio-</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Renal Vascular Dis.</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>4-4-57</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb 1, 1957</u> , to <u>Feb 1, 1957</u> , that I last saw the deceased alive on <u>Feb 1, 1957</u> , and that death occurred at <u>9:30</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>Charles F. Donald</u>				ADDRESS (Street, city, town, state) <u>7501 York Rd. 21157</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/4/57</u>		NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
24. REC'D BY REGISTRAR <u>FEB 4 1957</u>		REGISTRAR'S SIGNATURE <u>Nabel Gray</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tickner</u>		ADDRESS <u>North La Ave. Balt. Md.</u>	

CERTIFICATE OF DEATH

Form No. 1

TO BE FILLED BY THE REGISTRAR OF DEATHS

ATTEST: REGISTRAR

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

AGE OF DECEASED

SEX OF DECEASED

RACE OF DECEASED

EDUCATION OF DECEASED

RELIGION OF DECEASED

OCCUPATION OF DECEASED

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

DATE OF DEATH OF SPOUSE

NAME OF SPOUSE

DATE OF DEATH OF SPOUSE

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BUREAU V. 2

FEB 5 1957

RECEIVED

1563

CERTIFICATE OF DEATH

Reg. Dist. No.

21

1. PLACE OF DEATH o. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5501 Forest Park Ave.				d. STREET ADDRESS 5501 Forest Park Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EMMA Middle CARRIE Last SEEBO			4. DATE OF DEATH Month Feb. Day 9, Year 19 57				
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 7, 1884		9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Jacob Graf				14. MOTHER'S MAIDEN NAME Barbara Trotenbrodt			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) none		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Margaret Reed - 5501 Forest Park Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertension C. V. Disease 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Bypass DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June , 19 34 , to Feb 9 , 19 57 , that I last saw the deceased alive on Feb 8 , 19 57 , and that death occurred at 6:34 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Walter S. Smith M.D. 172946 Fayette St 2/9/57 PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/12/57		22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem.		22d. LOCATION (City, town, or county) (State) Pikesville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Dickner & Sons - Balt 17th				24a. REC'D BY REGISTRAR DATE 1-11-57		24b. REGISTRAR'S SIGNATURE Dr. Wm. E. Martin	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES J. JONES		2. SEX Male	
3. AGE 45		4. RACE White	
5. DATE OF DEATH JAN 15 1957		6. PLACE OF DEATH Home	
7. CAUSE OF DEATH Heart Disease		8. MANNER OF DEATH Natural	
9. SIGNATURE OF PHYSICIAN J. J. Jones		10. SIGNATURE OF REGISTRAR J. J. Jones	
11. SIGNATURE OF DECEASED J. J. Jones		12. SIGNATURE OF WITNESSES J. J. Jones	
13. SIGNATURE OF FUNERAL HOME J. J. Jones		14. SIGNATURE OF BURIAL PLACE J. J. Jones	
15. SIGNATURE OF CEMETERY J. J. Jones		16. SIGNATURE OF INTERVIEWER J. J. Jones	
17. SIGNATURE OF INTERVIEWER J. J. Jones		18. SIGNATURE OF INTERVIEWER J. J. Jones	
19. SIGNATURE OF INTERVIEWER J. J. Jones		20. SIGNATURE OF INTERVIEWER J. J. Jones	
21. SIGNATURE OF INTERVIEWER J. J. Jones		22. SIGNATURE OF INTERVIEWER J. J. Jones	
23. SIGNATURE OF INTERVIEWER J. J. Jones		24. SIGNATURE OF INTERVIEWER J. J. Jones	
25. SIGNATURE OF INTERVIEWER J. J. Jones		26. SIGNATURE OF INTERVIEWER J. J. Jones	
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29. SIGNATURE OF INTERVIEWER J. J. Jones		30. SIGNATURE OF INTERVIEWER J. J. Jones	
31. SIGNATURE OF INTERVIEWER J. J. Jones		32. SIGNATURE OF INTERVIEWER J. J. Jones	
33. SIGNATURE OF INTERVIEWER J. J. Jones		34. SIGNATURE OF INTERVIEWER J. J. Jones	
35. SIGNATURE OF INTERVIEWER J. J. Jones		36. SIGNATURE OF INTERVIEWER J. J. Jones	
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41. SIGNATURE OF INTERVIEWER J. J. Jones		42. SIGNATURE OF INTERVIEWER J. J. Jones	
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47. SIGNATURE OF INTERVIEWER J. J. Jones		48. SIGNATURE OF INTERVIEWER J. J. Jones	
49. SIGNATURE OF INTERVIEWER J. J. Jones		50. SIGNATURE OF INTERVIEWER J. J. Jones	
51. SIGNATURE OF INTERVIEWER J. J. Jones		52. SIGNATURE OF INTERVIEWER J. J. Jones	
53. SIGNATURE OF INTERVIEWER J. J. Jones		54. SIGNATURE OF INTERVIEWER J. J. Jones	
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57. SIGNATURE OF INTERVIEWER J. J. Jones		58. SIGNATURE OF INTERVIEWER J. J. Jones	
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63. SIGNATURE OF INTERVIEWER J. J. Jones		64. SIGNATURE OF INTERVIEWER J. J. Jones	
65. SIGNATURE OF INTERVIEWER J. J. Jones		66. SIGNATURE OF INTERVIEWER J. J. Jones	
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69. SIGNATURE OF INTERVIEWER J. J. Jones		70. SIGNATURE OF INTERVIEWER J. J. Jones	
71. SIGNATURE OF INTERVIEWER J. J. Jones		72. SIGNATURE OF INTERVIEWER J. J. Jones	
73. SIGNATURE OF INTERVIEWER J. J. Jones		74. SIGNATURE OF INTERVIEWER J. J. Jones	
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79. SIGNATURE OF INTERVIEWER J. J. Jones		80. SIGNATURE OF INTERVIEWER J. J. Jones	
81. SIGNATURE OF INTERVIEWER J. J. Jones		82. SIGNATURE OF INTERVIEWER J. J. Jones	
83. SIGNATURE OF INTERVIEWER J. J. Jones		84. SIGNATURE OF INTERVIEWER J. J. Jones	
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87. SIGNATURE OF INTERVIEWER J. J. Jones		88. SIGNATURE OF INTERVIEWER J. J. Jones	
89. SIGNATURE OF INTERVIEWER J. J. Jones		90. SIGNATURE OF INTERVIEWER J. J. Jones	
91. SIGNATURE OF INTERVIEWER J. J. Jones		92. SIGNATURE OF INTERVIEWER J. J. Jones	
93. SIGNATURE OF INTERVIEWER J. J. Jones		94. SIGNATURE OF INTERVIEWER J. J. Jones	
95. SIGNATURE OF INTERVIEWER J. J. Jones		96. SIGNATURE OF INTERVIEWER J. J. Jones	
97. SIGNATURE OF INTERVIEWER J. J. Jones		98. SIGNATURE OF INTERVIEWER J. J. Jones	
99. SIGNATURE OF INTERVIEWER J. J. Jones		100. SIGNATURE OF INTERVIEWER J. J. Jones	

RECEIVED
BUREAU V. 2
FEB 14 1957

1564

CERTIFICATE OF DEATH

Reg. Dist. No.

37

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Cockeysville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cedar Knoll Rd.				d. STREET ADDRESS Cedar Knoll Rd.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Idora Middle S. Last Shipley				4. DATE OF DEATH Month 2-16-57 Day 19 Year 19			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-15-1864	
9. AGE (In years last birthday) 92 yrs.		IF UNDER 1 YEAR Months 92 Days 92 Hours 92 Min. 92		IF UNDER 24 HRS. Months 92 Days 92 Hours 92 Min. 92			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Brice MacKindry Shipley				14. MOTHER'S MAIDEN NAME Jane Buckingham			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. none		17. INFORMANT Harry V. Shipley, Jr., Cockeysville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastric hemorrhage 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Gastric ulcer DUE TO (c) Probably carcinoma stomach				INTERVAL BETWEEN ONSET AND DEATH 6 hrs. 8 pm 8 pm.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) cholelithiasis				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from July 1956 to Feb 16 1957 , that I last saw the deceased alive on Feb 16 1957 , and that death occurred at 12:15 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE E. Elizabeth B. Sherrill M.D.				ADDRESS (Street, city or town, state) Cockeysville, Md.			
DATE SIGNED 2/16/57							
PHYSICIAN'S NAME (Type) Elizabeth B. Sherrill				Cockeysville, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Entombment		22b. DATE THEREOF 2-20-57		22c. NAME OF CEMETERY OR CREMATORY Green Mount		22d. LOCATION (City, town, or county) (State) Baltimore 2, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE L. Scott Brooks				ADDRESS 622 York Rd., Md.		24a. REC'D BY REGISTRAR Frank Smith	
DATE FEB 20 1957							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Page No. 18

DATE OF DEATH		PLACE OF DEATH		MANNER OF DEATH	
FEBRUARY 20, 1957		BALTIMORE, MARYLAND		NATURAL	
AGE		SEX		RACE	
62		Male		White	
BIRTH DATE		BIRTH PLACE		EDUCATION	
JANUARY 1, 1895		BALTIMORE, MARYLAND		HIGH SCHOOL	
OCCUPATION		MARITAL STATUS		RELIGION	
LABORER		MARRIED		METHODIST	
PREVIOUS ILLNESS		SIGNS AND SYMPTOMS		CAUSE OF DEATH	
NONE		HEART DISEASE		CORONARY ARTERY DISEASE	
TREATMENT		HISTORY		POSTMORTEM	
NONE		NONE		NONE	
CERTIFICATE NO.		REGISTERED		FILED	
10000		YES		YES	
SIGNATURE		DATE		PLACE	
J. H. SMITH		FEBRUARY 20, 1957		BALTIMORE, MARYLAND	

RECEIVED
FEB 20 1957
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01570
46

1565

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) White Marsh				c. LENGTH OF STAY IN 1b X0 White Marsh			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 353, Philadelphia Road				d. STREET ADDRESS Box 353, Philadelphia Road.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First MARY Middle OLIVIA Last SHIPLEY				4. DATE OF DEATH Month February Day 26 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 22, 1883	
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Charles A. Green				14. MOTHER'S MAIDEN NAME Barbara E. Schepleng			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. ---		17. INFORMANT Address Mrs. Annie Williams Box 353, Philadelphia Road.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral apoplexy 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Cardio-vascular disease DUE TO (c) 2 yrs INTERVAL BETWEEN ONSET AND DEATH 4 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Feb 22 , 19 57 , to Feb 26 , 19 57 , that I last saw the deceased alive on Feb 26 , 19 57 , and that death occurred at 2 A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE J. M. Baumgardner M.D.				ADDRESS (Street, city or town, state) DATE SIGNED Balto 6 Md 2/27/57			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 1, 1957		22c. NAME OF CEMETERY OR CREMATORY Meadow Ridge		22d. LOCATION (City, town, or county) (State) Dorsey, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 2112 Dundalk Ave.				24a. REC'D BY REGISTRAR DATE 3/1/57		24b. REGISTRAR'S SIGNATURE Dr. Walter H. Himmelfarb	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
 1957
 CERTIFICATE OF DEATH

PLACE OF DEATH HOME		MARRIAGE YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
DATE OF DEATH 12-1-57		TIME OF DEATH 10:00 AM	
NAME OF DECEASED JOHN DOE		SEX MALE	
AGE 65		RACE WHITE	
OCCUPATION RETIRED		CAUSE OF DEATH HEART DISEASE	
PLACE OF BIRTH BALTIMORE, MD		DATE OF BIRTH 12-1-57	
NAME OF PHYSICIAN DR. J. SMITH		NAME OF HOSPITAL ST. JOSEPH'S	
NAME OF FUNERAL HOME ABC FUNERAL HOME		NAME OF BURIAL PLACE GREENWICH CEMETERY	
NAME OF NEXT OF KIN MRS. J. DOE		ADDRESS OF NEXT OF KIN 123 MAIN ST. BALTIMORE, MD	
NAME OF WITNESS J. SMITH		ADDRESS OF WITNESS 456 PINE ST. BALTIMORE, MD	
NAME OF REGISTRAR J. SMITH		ADDRESS OF REGISTRAR 789 OAK ST. BALTIMORE, MD	
NAME OF CLERK J. SMITH		ADDRESS OF CLERK 101 BROADWAY BALTIMORE, MD	

RECEIVED
 MAR 4 1957
 BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01571

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1566

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 3014 Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ridgeway Manor Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Earle L. Simpson				4. DATE OF DEATH Feb. 11/57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 23, 1898	
9. AGE (In years last birthday) 58 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Musician		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME Charles Simpson			
14. MOTHER'S MAIDEN NAME Edna Albaugh				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. 214 14 1804				17. INFORMANT Address Mrs. Lela Simpson (WIFE) 505 Wildwood PKWY			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 581.1 DUE TO Massive Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Esophageal Varicosities (c) Faure's Cirrhosis, Liver				INTERVAL BETWEEN ONSET AND DEATH 5 min 6 mo 5 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from NOV. 5, 1956 to FEB. 11, 1957 , that I last saw the deceased alive on FEB. 10, 1957 , and that death occurred at 1:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE John F. Schaefer M.D.				ADDRESS (Street, city or town, state) 401 RANDOM RD. BALTO. 29 MD.			
PHYSICIAN'S NAME (Type) JOHN F. SCHAEFER				DATE SIGNED FEB. 12, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 13/57		22c. NAME OF CEMETERY OR CREMATORY Woodlawn		22d. LOCATION (City, town, or county) (State) Woodlawn 7, Balto. MD	
23. FUNERAL DIRECTOR'S SIGNATURE Harry H. Witzke				ADDRESS 4101 Edmondson Ave		24a. REC'D BY REGISTRAR FEB 14 57	
24b. REGISTRAR'S SIGNATURE Alb. Schaefer							

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01572

1567

CERTIFICATE OF DEATH

Reg. Dist. No.

33

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cummings Mills</u>				c. LENGTH OF STAY IN 1b <u>3yrs 9mo 11da</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Baltimore 29</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood St. Dr. Sch.</u>				d. STREET ADDRESS <u>1 1015 St. Charles Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>William</u> Last <u>SKELPSA</u>				4. DATE OF DEATH Month <u>February</u> Day <u>9</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-26-47</u>	
9. AGE (In years last birthday) <u>9</u> yrs.		IF UNDER 1 YEAR Months <u>9</u> Days <u>9</u> Hours <u>9</u> Min.		IF UNDER 24 HRS. Months <u>9</u> Days <u>9</u> Hours <u>9</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>Vincent A. Skelpsa</u>				14. MOTHER'S MAIDEN NAME <u>Josephine Judith Naragochis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Hospital Records Rosewood Cummings Mills Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> 758.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hipochondrodystrophy (Hurler's Dis.)</u> since birth DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>April</u> , 19 <u>53</u> , to <u>Feb 9</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>February 9</u> , 19 <u>57</u> , and that death occurred at <u>12:25 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Rosewood, Cummings Mills, Md</u> DATE SIGNED <u>7/10/57</u> ACTUAL SIGNATURE <u>Viola Barrett Johns</u> M.D. <u>Rosewood, Cummings Mills, Md</u> PHYSICIAN'S NAME (Type) <u>C. W. Kuchanbas</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2-13-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MOST HOLY REDEEMER</u>		22d. LOCATION (City, town, or county) (State) <u>BE LAIR RD MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. W. Kuchanbas</u>				24a. REC'D BY REGISTRAR <u>FEB 13 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mary Elise</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

CERTIFICATE OF DEATH

1957

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
MARRIAGE		MARRIED		SINGLE		WIDOW		DIVORCED		SEPARATED		OTHER			
OCCUPATION		INDUSTRY		TRADE		PROFESSION		VOCATION		BUSINESS		OTHER			
EDUCATION		SCHOOL		COLLEGE		UNIVERSITY		OTHER		DEGREE		OTHER			
RELIGION		METHODIST		CATHOLIC		LUTHERAN		BAPTIST		OTHER		OTHER			
MANNER OF DEATH		NATURAL		ACCIDENT		SUICIDE		HOMICIDE		OTHER		OTHER			
CAUSE OF DEATH		HEART DISEASE		CANCER		STROKE		PNEUMONIA		TUBERCULOSIS		OTHER			
DATE OF DEATH		FEB 12 1957		TIME OF DEATH		10:00 AM		PLACE OF DEATH		HOME		HOSPITAL			
SIGNATURE OF PHYSICIAN		J. H. SMITH		DATE		FEB 12 1957		SIGNATURE OF CORONER		J. H. SMITH		DATE		FEB 12 1957	
SIGNATURE OF DECEASED				DATE				SIGNATURE OF WITNESS				DATE			

BUREAU V. S.

FEB 12 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01573

Reg. Dist. No.

46

1. PLACE OF DEATH a. COUNTY Balto MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Md b. COUNTY Balto			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) White Marsh				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) White Marsh			
				d. STREET ADDRESS / Red Lion Rd			
3. NAME OF DECEASED (Type or print) First Robert Middle Hall Last Smith				4. DATE OF DEATH Month Feb Day 7 Year 19 57			
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-2-08	9. AGE (In years last birthday) 48 yrs.	IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mch. Pump Man Cities Services Co.			10b. KIND OF BUSINESS OR INDUSTRY Baltimore Md.		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Robert X. Smith				14. MOTHER'S MAIDEN NAME Not Known			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 11/4/43* 45		17. INFORMANT Frances Smith Red Lion Rd White Marsh			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crush Injuries head and chest DUE TO Auto Accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO 							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto Accident---collision					
20c. TIME OF INJURY Hour a. m. 19 Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rt 40	20f. (City or town) White Marsh	(County) Balto	(State) Md		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John C. Hyle				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John C. Hyle				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/11/57		22c. NAME OF CEMETERY OR CREMATORY National Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Hoffmann Funeral Home 3218 Hudson St.				24a. REC'D BY REGISTRAR Dr. Walter Hammett		24b. REGISTRAR'S SIGNATURE Dr. Walter Hammett	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

ALABAMA STATE DEPARTMENT OF HEALTH - BIRMINGHAM, ALA.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES EARL RAY		35		M		W		4-4-68		MEMPHIS, TENN.	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		CAUSE OF DEATH		MANNER OF DEATH	
ATTORNEY		HIGH SCHOOL		MARRIED		METHODIST		HEART DISEASE		SUICIDE	
BIRTH DATE		BIRTH PLACE		MOTHER'S NAME		FATHER'S NAME		PREVIOUS ILLNESS		TREATMENT	
1-1-28		MEMPHIS, TENN.		JANE RAY		JAMES EARL RAY		NONE		NONE	
DATE OF BIRTH		PLACE OF BIRTH		MOTHER'S BIRTH DATE		FATHER'S BIRTH DATE		DATE OF LAST ILLNESS		DATE OF DEATH	
1-1-28		MEMPHIS, TENN.		1-1-28		1-1-28		4-4-68		4-4-68	
DATE OF DEATH		PLACE OF DEATH		DATE OF BURIAL		PLACE OF BURIAL		DATE OF EXAMINATION		PLACE OF EXAMINATION	
4-4-68		MEMPHIS, TENN.		4-4-68		MEMPHIS, TENN.		4-4-68		MEMPHIS, TENN.	

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FEB 11 1968
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film G211 2-28-57 et

CERTIFICATE OF DEATH

01574

Reg. Dist. No.

1569

1. PLACE OF DEATH a. COUNTY <i>Baltimore Co</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville 52</i>	
3. NAME OF DECEASED (Type or print) <i>Catherine E. Snair</i>		d. STREET ADDRESS <i>2525 Old Frederick Rd</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Catherine E. Snair</i>		4. DATE OF DEATH Month <i>2</i> Day <i>19</i> Year <i>1957</i>	
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>3-27-1874</i>	
9. AGE (In years last birthday) <i>82</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>at home</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>Adam Snair</i>		14. MOTHER'S MARDEN NAME <i>✓</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no. or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Joseph Kramer</i>		Address <i>-2525 Old Frederick Rd</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac failure</i> <i>422.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic Cardio Vasc Disease</i> DUE TO (c) <i>Ast.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>6 hrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>1- Intestinal obstruction</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>2/6</i> , 1957, to <i>2/19</i> , 1957, that I last saw the deceased alive on <i>2/14</i> , 1957, and that death occurred at <i>1:45</i> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Cliff Ratliff J.</i>		DATE SIGNED <i>2/19/57</i>	
PHYSICIAN'S NAME (Type) <i>CLIFF RATLIFF, JR.</i>		ADDRESS (Street, city or town, state) <i>4605 Edmondson ave</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>2/22/57</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>St Stephens</i>		22d. LOCATION (City, town, or county) (State) <i>Harford Co Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Mac Hobb's Son - Catonsville</i>		24a. REG'D BY REGISTRAR DATE <i>FEB 25 57</i>	
24b. REGISTRAR'S SIGNATURE <i>W. Beach</i>			

CERTIFICATE OF DEATH

THE DEPT. OF HEALTH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. TIME OF DEATH		10. CAUSE OF DEATH	
11. PLACE OF DEATH		12. NAME OF PHYSICIAN		13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF REGISTRAR		15. DATE OF REGISTRATION	
16. NAME OF FUNERAL HOME		17. ADDRESS OF FUNERAL HOME		18. CITY AND STATE OF FUNERAL HOME		19. NAME OF MINISTER		20. ADDRESS OF MINISTER	
21. NAME OF NEXT OF KIN		22. ADDRESS OF NEXT OF KIN		23. CITY AND STATE OF NEXT OF KIN		24. NAME OF BURIAL PLACE		25. ADDRESS OF BURIAL PLACE	
26. NAME OF CEMETERY		27. ADDRESS OF CEMETERY		28. CITY AND STATE OF CEMETERY		29. NAME OF CLERGYMAN		30. ADDRESS OF CLERGYMAN	
31. NAME OF CHURCH		32. ADDRESS OF CHURCH		33. CITY AND STATE OF CHURCH		34. NAME OF MINISTER		35. ADDRESS OF MINISTER	
36. NAME OF FUNERAL HOME		37. ADDRESS OF FUNERAL HOME		38. CITY AND STATE OF FUNERAL HOME		39. NAME OF MINISTER		40. ADDRESS OF MINISTER	
41. NAME OF NEXT OF KIN		42. ADDRESS OF NEXT OF KIN		43. CITY AND STATE OF NEXT OF KIN		44. NAME OF BURIAL PLACE		45. ADDRESS OF BURIAL PLACE	
46. NAME OF CEMETERY		47. ADDRESS OF CEMETERY		48. CITY AND STATE OF CEMETERY		49. NAME OF CLERGYMAN		50. ADDRESS OF CLERGYMAN	
51. NAME OF CHURCH		52. ADDRESS OF CHURCH		53. CITY AND STATE OF CHURCH		54. NAME OF MINISTER		55. ADDRESS OF MINISTER	
56. NAME OF FUNERAL HOME		57. ADDRESS OF FUNERAL HOME		58. CITY AND STATE OF FUNERAL HOME		59. NAME OF MINISTER		60. ADDRESS OF MINISTER	
61. NAME OF NEXT OF KIN		62. ADDRESS OF NEXT OF KIN		63. CITY AND STATE OF NEXT OF KIN		64. NAME OF BURIAL PLACE		65. ADDRESS OF BURIAL PLACE	
66. NAME OF CEMETERY		67. ADDRESS OF CEMETERY		68. CITY AND STATE OF CEMETERY		69. NAME OF CLERGYMAN		70. ADDRESS OF CLERGYMAN	
71. NAME OF CHURCH		72. ADDRESS OF CHURCH		73. CITY AND STATE OF CHURCH		74. NAME OF MINISTER		75. ADDRESS OF MINISTER	
76. NAME OF FUNERAL HOME		77. ADDRESS OF FUNERAL HOME		78. CITY AND STATE OF FUNERAL HOME		79. NAME OF MINISTER		80. ADDRESS OF MINISTER	
81. NAME OF NEXT OF KIN		82. ADDRESS OF NEXT OF KIN		83. CITY AND STATE OF NEXT OF KIN		84. NAME OF BURIAL PLACE		85. ADDRESS OF BURIAL PLACE	
86. NAME OF CEMETERY		87. ADDRESS OF CEMETERY		88. CITY AND STATE OF CEMETERY		89. NAME OF CLERGYMAN		90. ADDRESS OF CLERGYMAN	
91. NAME OF CHURCH		92. ADDRESS OF CHURCH		93. CITY AND STATE OF CHURCH		94. NAME OF MINISTER		95. ADDRESS OF MINISTER	
96. NAME OF FUNERAL HOME		97. ADDRESS OF FUNERAL HOME		98. CITY AND STATE OF FUNERAL HOME		99. NAME OF MINISTER		100. ADDRESS OF MINISTER	

BUREAU V. S.

FEB 25 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

0157533

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Penna. b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills				c. LENGTH OF STAY IN 1b 5 mos.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ Huntingdon Valley 75X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Reisterstown Road				d. STREET ADDRESS 339 Felix Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Roy Middle William Last Speechley				4. DATE OF DEATH Month Feb. Day 22 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 2, 1900	
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Executive at Thompson Tractor				10b. KIND OF BUSINESS OR INDUSTRY Penna.		11. BIRTHPLACE (State or foreign country) U.S.A.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Stanford Speechley				14. MOTHER'S MAIDEN NAME Hueber			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 166-07-3551		17. INFORMANT Earl S. Speechley, Huntingdon Valley, Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none INTERVAL BETWEEN ONSET AND DEATH 6 hrs.							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. none				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. none 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) none	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE D. D. Caples				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) D. D. Caples, M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 2-23-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 25, 1957		22c. NAME OF CEMETERY OR CREMATORY North Cedar Hill		22d. LOCATION (City, town, or county) (State) Philadelphia, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Eline & Sons, Reisterstown, Md.				24a. REC'D BY REGISTRAR DATE 2-23-57		24b. REGISTRAR'S SIGNATURE Mary B. S. Line	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED
FEB 26 1957
BUREAU OF

FEB 26 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01576

Reg. Dist. No.

43

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u> c. LENGTH OF STAY IN lb <u>3 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7 Bel Haven Drive</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u> d. STREET ADDRESS <u>7 Bel Haven Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Nelson</u> Middle <u>B.</u> Last <u>Spicer</u>		4. DATE OF DEATH Month <u>February</u> Day <u>17</u> Year <u>19 57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 9, 1893</u>
9. AGE (In years last birthday) <u>63</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Harford Co., Md.</u>	
11. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>George Spicer</u>		14. MOTHER'S MAIDEN NAME <u>Louisa Turner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-01-7528</u>	
17. INFORMANT <u>Mrs. Della E. Spicer</u>		Address <u>7 Bel Haven Drive</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GUN SHOT WOUND Thru Left</u> <u>976x</u> DUE TO <u>Chest (12 Gauge)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot Self Thru L. Chest @ 12 Gauge SHOT Gun</u>	
20c. TIME OF INJURY Month, Day, Year <u>2-17-57</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Overlea - Balto</u> (County) _____ (State) <u>Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>M. B. Davis M.D.</u>		DATE SIGNED <u>2-19-57</u>	
EXAMINER'S NAME (Type) <u>M. B. DAVIS M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 20, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mount Christian</u>		22d. LOCATION (City, town, or county) <u>Joppa, Md.</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lessahn Funeral Home</u>		24a. REC'D BY REGISTRAR <u>FEB 21 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Mrs. A. L. Hefner</u>		ADDRESS <u>7401 Belair Rd.</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1, 2 Film 210 2-10-57 et

01577

CERTIFICATE OF DEATH

Reg. Dist. No.

45

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middle River		c. LENGTH OF STAY IN 1b 10 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ivy Hall Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Clayton E. Steinacher Sr.		4. DATE OF DEATH Feb. 8, 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 20, 1898
9. AGE (In years (birthdays) yrs.) 58		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY Baugh Chem. Co.	
11. BIRTHPLACE (State or foreign country) Balto., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward W. Steinacher		14. MOTHER'S MAIDEN NAME Anna Grimm	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-07-9837	
17. INFORMANT Anna Steinacher		Address Box 480 Rt. 14 Carroll Island Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic Carcinoma DUE TO 162X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/17 , 195 6 , to 2/8 , 195 7 , that I last saw the deceased alive on 2/7 , 195 7 , and that death occurred at 10 P. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE A. L. Kolodny M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 1825 Eastern Rd. Balto., Md. 2/9/57	
PHYSICIAN'S NAME (Type) A. L. Kolodny			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-11-57	
22c. NAME OF CEMETERY OR CREMATORY Ebenezer Meth. Cem.		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Larsen Funeral Home 7401 Belair Rd.		24a. REC'D BY REGISTRAR Edith Hurley	
24b. REGISTRAR'S SIGNATURE			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
John Doe		Male		38		Nov 10 1900		Maryland		Baltimore		Maryland		United States	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY	
Teacher		Heart Disease		Natural		Feb 14 1957		Baltimore		Maryland		Maryland		United States	
PREVIOUS ILLNESS		TREATMENT		DATE OF EXAMINATION		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY	
None		None		Feb 14 1957		Feb 14 1957		Baltimore		Maryland		Maryland		United States	
SIGNATURE OF PHYSICIAN		SIGNATURE OF DEATH REGISTRAR		DATE OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY	
[Signature]		[Signature]		Feb 14 1957		Feb 14 1957		Baltimore		Maryland		Maryland		United States	

BUREAU V. 2

FEB 14 1957

RECEIVED

Handwritten signature/initials

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1573

CERTIFICATE OF DEATH

01578

Reg. Dist. No. 184

1. PLACE OF DEATH o. COUNTY <u>Baltimore, TOWSON.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen. (Rural)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Towson Convalescent Home</u>		d. STREET ADDRESS <u>12X22</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Samuel</u> Middle <u>Stone</u> Last <u>Stone</u>		4. DATE OF DEATH Month <u>February</u> Day <u>10</u> Year <u>19 57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>21 Feb. 1869</u>
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Miner (Retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Metal. (Silver)</u>	
11. BIRTHPLACE (State or foreign country) <u>Cornwall, England</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Stone</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Rogers</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Ruth M. Berg.</u>		Address <u>R.D. 2 Aberdeen, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular Disease</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Anterior foramen</u> DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> (b) <u> </u> (c) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-1</u> , 19 <u>57</u> , to <u>2-10</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2-10</u> , 19 <u>57</u> , and that death occurred at <u>2:10 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Laurence C. Post</u>		ADDRESS (Street, city or town, state) <u>6805 York Rd Baltimore 12 Md</u>	
PHYSICIAN'S NAME (Type) <u>LAURENCE C. Post</u>		DATE SIGNED <u>2-10-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>2/12/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fairmount Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Denver Colorado</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John E. Barry</u>		ADDRESS <u>Aberdeen Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>Feb-12-57</u>		24b. REGISTRAR'S SIGNATURE <u>William E. Barry</u> <u>Maiba Gray</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1057

NAME OF DECEASED [Faint text, possibly "JOHN J. ..."]		SEX [Faint text, possibly "M"]	
AGE [Faint text, possibly "45"]		DATE OF BIRTH [Faint text, possibly "10/15/1912"]	
PLACE OF BIRTH [Faint text, possibly "BALTIMORE, MD"]		OCCUPATION [Faint text, possibly "LABORER"]	
CAUSE OF DEATH [Faint text, possibly "HEART DISEASE"]		MANNER OF DEATH [Faint text, possibly "NATURAL"]	
DATE OF DEATH [Faint text, possibly "10/25/1957"]		TIME OF DEATH [Faint text, possibly "10:30 AM"]	
PLACE OF DEATH [Faint text, possibly "HOME"]		COUNTY [Faint text, possibly "BALTIMORE"]	
SIGNATURE OF PHYSICIAN [Faint signature]		SIGNATURE OF REGISTRAR [Faint signature]	
SIGNATURE OF DECEASED [Faint signature]		SIGNATURE OF WITNESS [Faint signature]	

BUREAU V. 2

1057

RECEIVED

John J. ...
 2/12/27
 [Faint handwritten notes]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

01579

1574

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 34 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 111 Albemarle Street	
3. NAME OF DECEASED (Type or print) First CHARLES Middle B. Last STOUFFER		4. DATE OF DEATH Month February Day 25 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 28, 1915
9. AGE (In years last birthday) 41 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Automobile Garage	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Warren Stouffer		14. MOTHER'S MAIDEN NAME Jessie Buckingham	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW II		16. SOCIAL SECURITY NO. 220-01-0840	
17. INFORMANT Clin. Records, Vet. Adm. Hospital, Ft. Howard, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA, RIGHT LOWER LOBE AND PULMONARY EDEMA, BILATERAL 490X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) MALIGNANT MELANOMA, MULTIPLE METASTASIS DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 4 DAYS UNKNOWN			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that VA attended the deceased from January 22 , 19 57 , to February 25 19 57 , and that death occurred at 5:55 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Rolando D. Ponce de Leon M.D. VAH, FORT HOWARD, MARYLAND		DATE SIGNED 2/26/57	
PHYSICIAN'S NAME (Type) ROLANDO D. PONCE de LEON, M.D., VAH, FORT HOWARD, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-28-57	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery Baltimore, Maryland		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Blight, Inc. ADDRESS 6009 Harford Rd., Balto., Md.		24a. REC'D BY REGISTRAR DAWSON L. FARLEY 24b. REGISTRAR'S SIGNATURE DAWSON L. FARLEY	
DATE MAR 4 1957			

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE	
JAMES H. HARRIS		Male		32	
RESIDENCE		DATE OF DEATH		PLACE OF DEATH	
1111 Lexington Street		February 20, 1912		Home	
CAUSE OF DEATH		MANNER OF DEATH		MEDICAL ATTENDANT	
Automobile Injury		Accident		J. H. Harris	
DETAILS OF CASE		DATE OF BURIAL		PLACE OF BURIAL	
Buried in the City of Baltimore		February 22, 1912		St. James Cemetery	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES		SIGNATURE OF MEDICAL ATTENDANT	
				J. H. Harris	

BUREAU V. S.

MAR 5 1912

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01580

Reg. Dist. No.

1575

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rosedale Md.</u>				c. LENGTH OF STAY IN 1b <u>X 2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8325 Philadelphia Rd.</u>				d. STREET ADDRESS <u>8325 Philadelphia Road</u>			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CAROLINE</u> <u>STREIT</u>				4. DATE OF DEATH Month Day Year <u>FEB</u> <u>20</u> <u>19 57</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 24, 1877</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Czechoslovakia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Gustav Streit</u>				14. MOTHER'S MAIDEN NAME <u>Antonia</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>none</u>		17. INFORMANT Address <u>Gustav Streit (brother) 8325 Philadelphia Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH <u>10 min. to 1 hr.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>JAN</u> , 19 <u>52</u> , to <u>FEB, 20</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>FEB. 20</u> , 19 <u>57</u> , and that death occurred at <u>3:45 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>James R. Mason, M.D.</u> <u>8019 Philadelphia Road</u> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <u>James R. Mason M.D.</u> <u>Baltimore 6, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>cremation</u>		<u>2/23/57</u>		<u>Greenmount Crematory</u>		<u>Greenmount Ave & North Aves.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Schimunek Funeral 2601-03-05 E. Madison</u>				24a. REC'D BY REGISTRAR <u>Feb 25 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Edith Hurley</u>	

BUREAU V. S.

FEB 25 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01581

CERTIFICATE OF DEATH

Reg. Dist. No.

31

1. PLACE OF DEATH o. COUNTY Balto. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XO Randallstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Tower Rd.		d. STREET ADDRESS 1 Tower Rd.	
3. NAME OF DECEASED (Type or print) First FRANK Middle E. Last STRICKLER		4. DATE OF DEATH Month Feb. Day 6. Year 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 12, 1881
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Watchman		10b. KIND OF BUSINESS OR INDUSTRY Trucking	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Edward Strickler		14. MOTHER'S MAIDEN NAME Mary Katherine (Poulton)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. Irvin L. Strickler-Tower Rd., Randallstown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial Insufficiency 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic heart DUE TO (c) vascular disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2/4/57			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/18, 57 , to 2/4, 1957 , that I last saw the deceased alive on 2/4, 1957 , and that death occurred at 107 E. West St. 2/8/57 M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE E. S. ELLISON M.D. Balto 30, Md. PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/11/57	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Lickner & Sons - Balto, Md.		24a. REC'D BY REGISTRAR FEB 13 1957	
24b. REGISTRAR'S SIGNATURE Wm. E. Martin			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

FILE NO.

Form with multiple sections for death certificate data, including fields for name, date, and cause of death.

BUREAU V. 1

FEB 13 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1577

CERTIFICATE OF DEATH

01582

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 3yr8mth26dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Anna Middle MABEL Last Sunderland		4. DATE OF DEATH February 16 19 57	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 16, 1898
9. AGE (In years last birthday) 58 yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) teacher - housewife		10b. KIND OF BUSINESS OR INDUSTRY at home	
11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Marion Irvin		14. MOTHER'S MAIDEN NAME Anna Bodine	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) C. U. A 443x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive arteriosclerotic cardiovascular disease DUE TO (c) liver disease		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 14, 1957 , to Feb. 16, 1957 , that I last saw the deceased alive on Feb. 16, 1957 , and that death occurred at 8 1/2 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. Gertrude J. Fleischman M.D.		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 2.16.1957	
PHYSICIAN'S NAME (Type) GERTRUDE J. FLEISCHMAN		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/19/57	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		22d. LOCATION (City, town, or county) (State) Witcher Hwy Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Lowman		ADDRESS 901 Hollis St.	
24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE DATE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 8

FEB 19 1957

RECEIVED

1578 CERTIFICATE OF DEATH

Reg. Dist. No.

1. NAME OF DECEASED (Type or Print) John Taylor		2. DATE OF DEATH 2/18/57	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Baltimore County</i>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore	
B. FULL NAME OF (If not in hospital or institution, give street address or location) INSTITUTION <i>Marshy Point Rd.</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Chase, Maryland	
c. Length of stay in Baltimore 5 Yrs. 11/11/51 Mos. 11/11/51 Days		D. STREET ADDRESS (If rural, give location) Marshy Point Road	
5. SEX Male	6. COLOR OR RACE Col.	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 65
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wilbert Taylor		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Daisy Ellis		ADDRESS Same	

18. 422.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Cerebral apoplexy Sudden	CAUSE OF DEATH Cerebral apoplexy Sudden	INTERVAL BETWEEN ONSET AND DEATH Sudden
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Arteriosclerotic Cardio-Vascular Disease 2 yrs	DUE TO (A) Cerebral apoplexy Sudden (B) Arteriosclerotic Cardio-Vascular Disease 2 yrs (C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. TIME (Month) (Day) (Year) (Hour) OF INJURY	21B. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from Jan 1, 1957 to Feb 18, 1957 , that I last saw the deceased alive on Feb 18, 1957 and that death occurred at 9 A.M. , from the causes and on the date stated above.		
23A. SIGNATURE J. M. Baumgardner	23B. ADDRESS Baeto 6 Md	23C. DATE SIGNED 2/18/57
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 2/24/57	24C. NAME OF CEMETERY OR CREMATORY Mt Calvary
24D. LOCATION (City, town, or county) Brooklyn Md. N.A.C.		24E. STATE Md.
DATE RECEIVED BY LOCAL REGISTRAR Feb 23-1957	REGISTRAR'S SIGNATURE R. W. Dawson	25. FUNERAL DIRECTOR Chas. O. Wilcox
ADDRESS 1000 Grantham Ave		

BUREAU V. S.

FEB 26 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(S)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1575 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01584

Reg. Dist. No. 33

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Parkton</u>		c. LENGTH OF STAY IN 1b <u>17 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harris Mill Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Martha Emma Taylor</u>		4. DATE OF DEATH <u>February 7</u> 1957	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 18, 1898</u> 38 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Canning Factory Dauphin Co., Pa.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Jones</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>197-220771</u>	
17. INFORMANT <u>Mrs. Carl Tracy, White Hall Md.</u>		Address <u>White Hall Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>A. M. France</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>A. M. FRANCE</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb 10, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Bowers Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>New Freedom, Penna.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Isaac Hartenstein</u>		24a. REC'D BY REGISTRAR <u>2/10/57</u>	
ADDRESS <u>New Freedom Pa.</u>		24b. REGISTRAR'S SIGNATURE <u>Edwin G. Engle</u>	

FEB 13 1957

RECEIVED

1580

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>REISTERSTOWN RURAL</u>		c. LENGTH OF STAY IN 1b <u>1 WEEK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PARKTON RURAL XI</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HANOVER PIKE</u>				d. STREET ADDRESS <u>MT. CARMEL</u>			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Barbara</u> Middle <u>Ellen</u> Last <u>Thompson</u>				4. DATE OF DEATH Month <u>FEBRUARY</u> Day <u>13</u> Year <u>1957</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 26, 1877</u>	9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John T. Thompson</u>				14. MOTHER'S MAIDEN NAME <u>Ellen Johnson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>CARROLL THOMPSON</u> Address <u>PARKTON, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage.</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardio-Vascular Disease.</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> (?)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
				20f. (City or town) _____		(County) _____ (State) _____	
21. I certify that I attended the deceased from <u>JAN 1</u> , 19 <u>56</u> , to <u>February 13</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>February 13</u> , 19 <u>57</u> , and that death occurred at <u>12:15 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Joseph E. Bush</u> M.D.				ADDRESS (Street, city or town, state) <u>Hampstead Md</u>			
PHYSICIAN'S NAME (Type) <u>Joseph E. Bush MD</u>				DATE SIGNED <u>2/13/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Febr 16, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Parkton Balto. Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Isaac Hartenstein, New Freedom, Pa.</u>				24a. REC'D BY REGISTRAR <u>FLB 18 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mary Eline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

FEB 15 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01586

1440

CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus		c. LENGTH OF STAY IN 1b 51	
d. NAME OF HOSPITAL (If not in hospital, give street address) 4136 Wilkens Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mamie First P. Middle Thompson Last		4. DATE OF DEATH February 12, 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 19, 1889
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Belair, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John H. Cox		14. MOTHER'S MAIDEN NAME Nellie Albaugh	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Charles E. Thompson		Address 4136 Wilkens Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 174x Carcinoma of Uterus DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 8 mos.		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December, 1956 , to Feb. 12, 1957 , that I last saw the deceased alive on Feb. 10, 1957 , and that death occurred at 5 P. M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE D. C. MacLaughlin M.D.		ADDRESS (Street, city or town, state) 4508 Edmondson Village	
PHYSICIAN'S NAME (Type) D. C. MacLaughlin, M.D.		DATE SIGNED 2/14/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-19-57	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		ADDRESS 4107 Wilkens Avenue	
24a. REC'D BY REGISTRAR DATE 2/15/57		24b. REGISTRAR'S SIGNATURE Dr. Jas. Krueffer	

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01587

Reg. Dist. No.

33

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore City ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glyndon		c. LENGTH OF STAY IN 1b emp. 20 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore- 223 Vol 1-4			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sagamore Farms				d. STREET ADDRESS 2805 Elsinor Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Isaac Middle J. Last Tittle				4. DATE OF DEATH Month Feb. Day 17 Year 1957			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar. 1, 1895		9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Groom		10b. KIND OF BUSINESS OR INDUSTRY Race Horsing		11. BIRTHPLACE (State or foreign country) Melvale, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME unknown				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) yes WWI		16. SOCIAL SECURITY NO. 217-07-5623		17. INFORMANT Susan Tittle, 2805 Elsinor Ave., Balto.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none							INTERVAL BETWEEN ONSET AND DEATH 10 min.
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none					
20c. TIME OF INJURY Month, Day, Year Hour o. m. none 19 p. m.		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) none (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE D. D. Caples				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) D. D. Caples, M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		2-18-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-21-57		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Earl Gilmore, 519 Mosher St.				24a. REC'D BY REGISTRAR Feb 19 1957		24b. REGISTRAR'S SIGNATURE Mary Elmer	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

FEB 19 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

1582

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>Pyromthllds</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Katherine</u> Middle <u>A.</u> Last <u>Tomlinson</u>		4. DATE OF DEATH Month <u>February</u> Day <u>28</u> Year <u>19 57</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 16, 1879</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>George Dunigan</u>		14. MOTHER'S MAIDEN NAME <u>Agnes Dunigan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>1 day</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u> </u> <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb. 28, 1957</u> , to <u>Feb. 28, 1957</u> , that I last saw the deceased alive on <u>February 28, 1957</u> , and that death occurred at <u>10:35 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stella Wachslar</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>SPRING GROVE STATE HOSPITAL</u> <u>3-1-57</u>	
PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M. D.</u>		<u>Catonsville 28, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/5/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Dickner & Sons - Balto. 7 Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 4 57</u>	
24b. REGISTRAR'S SIGNATURE <u>Quelan!</u>			

MEDICAL CERTIFICATION

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01589

1583

CERTIFICATE OF DEATH

Reg. Dist. No.

43

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN 1b 17 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5808 Westwood Ave.		e. STREET ADDRESS 5808 Westwood Ave.	
3. NAME OF DECEASED (Type or print) First Catherine Middle E. Last Tormollan		4. DATE OF DEATH Month February Day 2 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 13, 1914
9. AGE (In years last birthday) 42		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Herman Reinhardt		14. MOTHER'S MAIDEN NAME Ernestina Loessin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 213-01-1851	
17. INFORMANT Mr. Owen E. Tormollan Jr.		Address 5808 Westwood Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremic Coma 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Intercapillary Glomerular Sclerosis (c) Diabetes Mellitus			INTERVAL BETWEEN ONSET AND DEATH 6-7 Hour 1 year 16 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-15 , 19 57 , to 2-2 , 19 57 , that I last saw the deceased alive on 2-2-57 , 19 57 , and that death occurred at 12:11 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Paul G. Mueller		ADDRESS (Street, city or town, state) 6331 Belair Rd.	
PHYSICIAN'S NAME (Type) Paul G. Mueller M.D.		DATE SIGNED 2/3/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 6, 1957	
22c. NAME OF CEMETERY OR CREMATORY Jerusalem Lutheran Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Sassam Funeral Home		ADDRESS 7401 Belair Road	
24a. REC'D BY REGISTRAR DATE 5 1957		24b. REGISTRAR'S SIGNATURE Miss A. L. Rupprecht	

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death	
John Doe		Male		45		1957-10-15	
Place of Birth		Race		Occupation		Cause of Death	
New York City		White		Teacher		Heart Disease	
Residence at Time of Death		Marital Status		Usual Residence		Place of Death	
123 Main St, Baltimore, MD		Married		123 Main St, Baltimore, MD		Home	
Physician		Hospital		Burial Place		Burial Date	
Dr. Smith		St. Mary's Hospital		Catholic Cemetery		1957-10-18	
Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Medical Examiner	

Wm. C. Jones
Autographist, Baltimore, Md.
1957-10-15

BUREAU V. 1

11-15 1957

11-15 1957

John Doe

123 Main St, Baltimore, Md.

RECEIVED

1957-10-15

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01590

1584

CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Providence	c. LENGTH OF STAY IN 1b Life	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Providence	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1612 Providence Rd.		d. STREET ADDRESS 1612 Providence Road	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Howard Middle M. Last Treadwell		4. DATE OF DEATH Feb. Month 15 Day 1957 Year 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 16 1869
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Black & Decker Co.	11. BIRTHPLACE (State or foreign country) Baltimore Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William S. Treadwell	
14. MOTHER'S MAIDEN NAME Virginia Nonn		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 220-05-8247		17. INFORMANT Mrs. Hazel Cranston Address 1612 Providence Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 442X DUE TO Acute Pulmonary Edema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardiac-Renal DUE TO Hypertensive Cardiac-Renal (c) Vascular Disease DUE TO Vascular Disease INTERVAL BETWEEN ONSET AND DEATH 15 yrs		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 1, 1957 to Feb 7, 1957 , that I last saw the deceased alive on Feb 7, 1957 , and that death occurred at M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles F. O'Donnell M.D.		ADDRESS (Street, city or town, state) 7501 York Rd	
PHYSICIAN'S NAME (Type) Charles F. O'Donnell M.D.		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	2-18-57	Providence Meth. Cem.	Baltimore Md.
23. FUNERAL DIRECTOR'S SIGNATURE Lillian F. H. H.		ADDRESS 7401 Belvoir Rd.	
24a. REC'D BY REGISTRAR Feb 18 1957		24b. REGISTRAR'S SIGNATURE Michael Gray	

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause, and location. The form is partially filled out with handwritten text.

BUREAU V. 2

FEB 19 1957

RECEIVED

Handwritten notes at the bottom of the page, including dates and names, such as "2-18-57" and "James M. Smith".

1585
CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE md b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE				c. LENGTH OF STAY IN 1b 17 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) SPRING GROVE ST. H.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LULA Middle TURNER Last TURNER				4. DATE OF DEATH Month 2 / Day 14 / Year 1957			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/25/1878	9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME BENJAMIN FRANK ARMINGER				14. MOTHER'S MAIDEN NAME SARAH E. HARRISON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Records. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arterio-sclerotic heart disease 420.0 DUE TO Advanced Senescent Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 260X DUE TO (b) — (c) —						INTERVAL BETWEEN ONSET AND DEATH years years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ① - Adeno-Ca. of Bladder ② Diabetes Mellitus						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Dec 6, 1940 , to Feb 14, 1957 , that I last saw the deceased alive on Feb 14, 1940 , and that death occurred at 8:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Charles Ward				ADDRESS (Street, city or town, state) Spring Grove, Md.			
PHYSICIAN'S NAME (Type) DR. CHARLES WARD				DATE SIGNED Feb 14, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		Feb 17, 1957		Smithville		Dunkirk Md	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. H. Hutchins				ADDRESS Owings Md		24a. REC'D BY REGISTRAR DATE 2-18-57	
						24b. REGISTRAR'S SIGNATURE N. W. Ward	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01592

1586 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 6mth7dys			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Edward Middle Hugh Last Ullery				4. DATE OF DEATH Month February Day 1 Year 19 57			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 2, 1873	9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farming		10b. KIND OF BUSINESS OR INDUSTRY farm		11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME UNKNOWN Newton Ullery				14. MOTHER'S MAIDEN NAME UNKNOWN Becky Booth			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 1898		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 446x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Senile arteriosclerotic nephrosclerosis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 24, 1956 , to Feb. 1, 1957 , that I last saw the deceased alive on Feb. 1, 1957 , and that death occurred at 2:15 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Stella Wachslar		M.D. SPRING GROVE STATE HOSPITAL		DATE SIGNED 2-1-57			
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		Catonsville 28, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/5/1957		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cem.		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co				ADDRESS 1400 Clapton St		24a. REC'D BY REGISTRAR FEB 6 57	
				24b. REGISTRAR'S SIGNATURE W. W. Chambers			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED [REDACTED]		SEX [REDACTED]		AGE [REDACTED]	
DATE OF BIRTH [REDACTED]		PLACE OF BIRTH [REDACTED]		RACE [REDACTED]	
DATE OF DEATH [REDACTED]		PLACE OF DEATH [REDACTED]		CAUSE OF DEATH [REDACTED]	
TIME OF DEATH [REDACTED]		MANNER OF DEATH [REDACTED]		MEDICAL HISTORY [REDACTED]	
OCCUPATION [REDACTED]		EDUCATION [REDACTED]		SOCIAL HISTORY [REDACTED]	
PREVIOUS ILLNESS [REDACTED]		PREVIOUS SURGERY [REDACTED]		PREVIOUS TRAUMA [REDACTED]	
PREVIOUS DRUGS [REDACTED]		PREVIOUS ALCOHOL [REDACTED]		PREVIOUS TOBACCO [REDACTED]	
PREVIOUS RADIATION [REDACTED]		PREVIOUS CHEMOTHERAPY [REDACTED]		PREVIOUS HORMONE THERAPY [REDACTED]	
PREVIOUS TRANSFUSION [REDACTED]		PREVIOUS ORGANS [REDACTED]		PREVIOUS TISSUES [REDACTED]	
PREVIOUS DONOR [REDACTED]		PREVIOUS RECIPIENT [REDACTED]		PREVIOUS TRANSPLANT [REDACTED]	
PREVIOUS GRAFT [REDACTED]		PREVIOUS IMPLANT [REDACTED]		PREVIOUS PROSTHESIS [REDACTED]	
PREVIOUS DEVICE [REDACTED]		PREVIOUS INSTRUMENT [REDACTED]		PREVIOUS EQUIPMENT [REDACTED]	
PREVIOUS SUPPLY [REDACTED]		PREVIOUS SERVICE [REDACTED]		PREVIOUS FACILITY [REDACTED]	
PREVIOUS PERSONNEL [REDACTED]		PREVIOUS PROCEDURE [REDACTED]		PREVIOUS RESULT [REDACTED]	
PREVIOUS COMMENT [REDACTED]		PREVIOUS SIGNATURE [REDACTED]		PREVIOUS DATE [REDACTED]	

BUREAU V. S.

FEB 6 1957

RECEIVED

1587

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 70 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 417 York Road		d. STREET ADDRESS 417 York Road	
3. NAME OF DECEASED (Type or print) First Anna Middle M. Last Urban		4. DATE OF DEATH Month February Day 19 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 9, 1860
9. AGE (In years last birthday) 97 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Theodore A. Bokel		14. MOTHER'S MAIDEN NAME Johanna Schroeder	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Miss Marguerite B. Urban		Address 417 York Road	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) GENERALIZED ARTERIOSCLEROSIS DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 WKS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1955 , 19____, to FEB 19 , 19 57 , that I last saw the deceased alive on FEB 19 , 19 57 , and that death occurred at 5:30 M., from the causes and on the date stated above.			
ACTUAL SIGNATURE T.C. SIKWINSKI		ADDRESS (Street, city or town, state) 17 W. PENNA. AVE DATE SIGNED 2/21/57	
PHYSICIAN'S NAME (Type) T.C. SIKWINSKI		TOWSON 4 Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/22/57	22c. NAME OF CEMETERY OR CREMATORY St. Mary's	22d. LOCATION (City, town, or county) (State) Govans Md.
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Meates and Son		24a. REC'D BY REGISTRAR 2-21-57	
ADDRESS 805 N. Calvert St.		24b. REGISTRAR'S SIGNATURE Mabel Gray	

FEB 25 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1588

CERTIFICATE OF DEATH

01594

Reg. Dist. No.

20

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 14 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Parkville, Maryland		d. STREET ADDRESS 3006 Lavender Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle C Last Vaughan		4. DATE OF DEATH Month 2 Day 26 Year 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 14, 1882
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) salesman		10b. KIND OF BUSINESS OR INDUSTRY New York	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME WILLIAM VAUGHAN unknown		14. MOTHER'S MAIDEN NAME ANNIE FEENEY unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. 133-10-1997 unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 446X DUE TO arteriosclerotic Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) Senile/nephrosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 15 , 19 57 , to 2/26 , 19 57 , that I last saw the deceased alive on 2/26 , 19 57 , and that death occurred at 8:40 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachsler		DATE SIGNED 2/26/57	
PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3-1-1957	
22c. NAME OF CEMETERY OR CREMATORY MORELAND MEMORIAL		22d. LOCATION (City, town, or county) (State) BALTIMORE MD	
23. FUNERAL DIRECTOR'S SIGNATURE Chas F EVANS & SON		24a. REC'D BY REGISTRAR 8802 HARFORD RD	
24b. REGISTRAR'S SIGNATURE A. W. Gedrich		DATE 2/27/57	

RECEIVED

1957 FEB 28

BUREAU V. S.

MAYNARD STATE DEPARTMENT OF HEALTH - BATHONE, 15		1535	
CERTIFICATE OF DEATH		1535	
1. NAME OF DECEASED		MAYNARD	
2. SEX		MALE	
3. AGE		30	
4. DATE OF BIRTH		1927	
5. PLACE OF BIRTH		BATHONE, MAYNARD	
6. OCCUPATION		LABORER	
7. CAUSE OF DEATH		HEART DISEASE	
8. DATE OF DEATH		1957	
9. PLACE OF DEATH		BATHONE, MAYNARD	
10. SIGNATURE OF DECEASED			
11. SIGNATURE OF WITNESS			
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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1589 CERTIFICATE OF DEATH

01595

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 1 Hour- 10 M.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 1224 Dukeland Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last JOHN VAUGHN				4. DATE OF DEATH Month Day Year February 15 19 57			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 4, 1887	
9. AGE (In years last birthday) 69 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stevodore		10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Essex County, Virginia	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Mary MN: Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		(If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Clinical Records, Vet. Adm. Hosp., Ft. Howard, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE LEPTOMENINGITIS 340.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from February 11, 1957, 3:30 P.M. to February 14, 1957, 4:40 P.M. and that death occurred at 4:40 P.M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND				DATE SIGNED 2/15/57			
ACTUAL SIGNATURE Rolando D. Ponce de Leon M.D.							
PHYSICIAN'S NAME (Type) ROLANDO D. PONCE de LEON, M.D.				VAH, FORT HOWARD, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/18/57		22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery Baltimore, Maryland		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law Mortuary, 802-04 Madison Ave.,				ADDRESS Baltimore 1, Md.			
24a. REC'D BY REGISTRAR Feb 20 1957				24b. REGISTRAR'S SIGNATURE Lawson L. Farley			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

THE STATE OF

MARYLAND

CITY OF BALTIMORE

DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

BUREAU V. R.

FEB 20 1957

RECEIVED

1590

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baets Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Baets</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wayne Conv. Home</u>				d. STREET ADDRESS <u>6603 Johnnycake Rd</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>VIVIAN</u> First <u>VICK</u> Middle <u>VICK</u> Last				4. DATE OF DEATH <u>2/22/57</u> Month <u>2</u> Day <u>22</u> Year <u>19</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 26, 1886</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>stockbroker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>retired</u>		11. BIRTHPLACE (State or foreign country) <u>Texas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Tobias Vick</u>				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U. S.-ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Mr Eugene J. Gerberg (same)</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO <u>Massive.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Multiple Small Strokes old with residual Aphasia</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>Mar 56</u> , to <u>Feb 57</u> , that I last saw the deceased alive on <u>2/21/57</u> , and that death occurred at <u>5:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. E. Mc Grath</u> M.D.				ADDRESS (Street, city or town, state) <u>1303 Frederick Rd</u>		DATE SIGNED <u>2/22/57</u>	
PHYSICIAN'S NAME (Type) <u>W. E. Mc Grath M.D. Catonsville 28 md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>2/23/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>London Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baets Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mr. Nabb & Son</u> ADDRESS <u>28</u>				24a. REC'D BY REGISTRAR <u>FEB 25 57</u> DATE		24b. REGISTRAR'S SIGNATURE <u>W. E. Mc Grath</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the registrar should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

1591

CERTIFICATE OF DEATH

01598

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto. Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Highway Manor</u>		d. STREET ADDRESS <u>16 N. Lymington Ave</u>	
3. NAME OF DECEASED (Type or print) <u>WALTER W. WADE</u>		4. DATE OF DEATH <u>2/8/57</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 20, 1901</u>
9. AGE (In years lost birthday) <u>55</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gar. Elec Co</u>	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Walter Upton</u>		14. MOTHER'S MAIDEN NAME <u>Fowler</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Cerebral Hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Posterior Coronary Infarction</u> (c) <u>Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>4 months</u> <u>2 yrs?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12:30</u> , 19 <u>56</u> , to <u>2:00</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2:48</u> , 19 <u>57</u> , and that death occurred at <u>12:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George E. Urban</u>		ADDRESS (Street, city or town, state) <u>805 Fred. Ave, Catonsville, Md.</u>	
PHYSICIAN'S NAME (Type) <u>George E. URBAN</u>		DATE SIGNED <u>2:00 PM</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/11/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt Olivet</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>McNabb + Son</u>		ADDRESS <u>28</u>	
24a. REC'D BY REGISTRAR <u>FEB 11 '57</u>		24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4

BUREAU V. S.

1957 11 FEB

RECEIVED

1592

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u>		c. LENGTH OF STAY IN 1b <u>3 day</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House in Lines</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>DOROTHEA M. WAGNER</u>		4. DATE OF DEATH <u>2/14/57</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 2, 1909</u>
9. AGE (In years last birthday) <u>47</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Joseph Ruppel</u>		14. MOTHER'S MAIDEN NAME <u>Mary Foreythe</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Wm. J. Wagner Sr. (Same)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastasis to Brain Vessel</u> <u>171X</u> DUE TO <u>Hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of Cervix & Metastases</u> DUE TO <u>to acc pelvic structure</u> (c) <u>1st stage metastasis caused by water abt.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> <u>2 yrs</u> <u>2 mo -</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 14, 1956</u> , to <u>Feb 14, 1957</u> , that I last saw the deceased alive on <u>Feb 14, 1957</u> , and that death occurred at <u>10 P. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>3603 ... Md.</u> DATE SIGNED <u>Chas. Norton Jr.</u>			
ACTUAL SIGNATURE <u>Chas. Norton Jr.</u>		M.D. <u>3603 ... Md.</u>	
PHYSICIAN'S NAME (Type) <u>J. Chas. Norton Jr. M.D.</u>		<u>Balto. 29 Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>2/18/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Londondale Park</u>	22d. LOCATION (City, town, or county) (State) <u>Balto. Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mac Math + Son</u>		ADDRESS <u>28</u>	
24a. REC'D BY REGISTRAR <u>FEB 19 57</u>		DATE <u>Feb 19 57</u>	
24b. REGISTRAR'S SIGNATURE <u>W. H. ...</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1593

CERTIFICATE OF DEATH

01600

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CECIL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PIKEVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u> 07-21-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>124 Hawthorne Ave-</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES Woodward Walker</u>		4. DATE OF DEATH Month Day Year <u>FEB. 24- 1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-27-1883</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TRUCK DRIVER</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Stanton, Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Adopted by WALKER family</u>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-05-4647B-</u>	
17. INFORMANT <u>Mrs. Sarah E Rhoads - 124 Hawthorne Ave</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>Chronic Myocarditis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Art. Sclerosis</u> DUE TO <u>3-4 yrs.</u> (c) <u>3-4 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>JAN. 1953</u> , to <u>FEBRUARY 1957</u> , that I last saw the deceased alive on <u>FEB. 24</u> 19 <u>57</u> , and that death occurred at <u>12:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James A. Miller M.D.</u>		ADDRESS (Street, city or town, state) <u>1331 Reist. Rd. Pikeville, Md.</u>	
PHYSICIAN'S NAME (Type) <u>James A. Miller M.D.</u>		DATE SIGNED <u>2/24/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>2/27/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Gilpin Manor Memorial Co. - Elkton, Maryland.</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. H. Russell</u>		ADDRESS <u>Pikeville, Md.</u>	
24a. REC'D BY REGISTRAR <u>FEB 28 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Moorthy Hewells</u>	

01800

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1953 - CERTIFICATE OF DEATH

1. NAME OF DECEASED [Blank]		2. SEX [Blank]	
3. AGE [Blank]		4. DATE OF BIRTH [Blank]	
5. PLACE OF BIRTH [Blank]		6. OCCUPATION [Blank]	
7. MARITAL STATUS [Blank]		8. CAUSE OF DEATH [Blank]	
9. MEDICAL HISTORY [Blank]		10. SIGNATURE OF PHYSICIAN [Blank]	
11. SIGNATURE OF DECEASED [Blank]		12. SIGNATURE OF WITNESS [Blank]	
13. SIGNATURE OF DECEASED [Blank]		14. SIGNATURE OF WITNESS [Blank]	
15. SIGNATURE OF DECEASED [Blank]		16. SIGNATURE OF WITNESS [Blank]	
17. SIGNATURE OF DECEASED [Blank]		18. SIGNATURE OF WITNESS [Blank]	
19. SIGNATURE OF DECEASED [Blank]		20. SIGNATURE OF WITNESS [Blank]	
21. SIGNATURE OF DECEASED [Blank]		22. SIGNATURE OF WITNESS [Blank]	
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25. SIGNATURE OF DECEASED [Blank]		26. SIGNATURE OF WITNESS [Blank]	
27. SIGNATURE OF DECEASED [Blank]		28. SIGNATURE OF WITNESS [Blank]	
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31. SIGNATURE OF DECEASED [Blank]		32. SIGNATURE OF WITNESS [Blank]	
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49. SIGNATURE OF DECEASED [Blank]		50. SIGNATURE OF WITNESS [Blank]	
51. SIGNATURE OF DECEASED [Blank]		52. SIGNATURE OF WITNESS [Blank]	
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61. SIGNATURE OF DECEASED [Blank]		62. SIGNATURE OF WITNESS [Blank]	
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89. SIGNATURE OF DECEASED [Blank]		90. SIGNATURE OF WITNESS [Blank]	
91. SIGNATURE OF DECEASED [Blank]		92. SIGNATURE OF WITNESS [Blank]	
93. SIGNATURE OF DECEASED [Blank]		94. SIGNATURE OF WITNESS [Blank]	
95. SIGNATURE OF DECEASED [Blank]		96. SIGNATURE OF WITNESS [Blank]	
97. SIGNATURE OF DECEASED [Blank]		98. SIGNATURE OF WITNESS [Blank]	
99. SIGNATURE OF DECEASED [Blank]		100. SIGNATURE OF WITNESS [Blank]	

BUREAU V. 3

FEB 28 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film 0211 3-4-57 et

1594

CERTIFICATE OF DEATH

01601

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN IB 22yr10mth14dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Grove State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Frank Middle Warminski Last Warminski		4. DATE OF DEATH Month February Day 22 Year 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 24, 1899
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months 57 Days 57 Hours 57 Min. 57	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME XXXXXXXX Peter Warminski		14. MOTHER'S MAIDEN NAME XXXXXXXX Bronislawa Mastrowicz	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterioscl. Cardiovascular Disease DUE TO (c) ---		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 22, 1957 , to Feb. 22, 1957 , that I last saw the deceased alive on Feb. 22, 1957 , and that death occurred at 4:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachslar M.D.		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 2-23-57	
PHYSICIAN'S NAME (Type) STELLA WACHSLER		Catonsville 28, Maryland 2/23/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF Feb. 25, 1957	22c. NAME OF CEMETERY OR CREMATORY St. Stanislaus	22d. LOCATION (City, town, or county) (State) Dundalk Ave. Balto. Md.
23. FUNERAL DIRECTOR'S SIGNATURE John J. Duda		24a. REC'D BY REGISTRAR FEB 26 57	
24b. REGISTRAR'S SIGNATURE W. J. Duda			

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

1595 CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>✓</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> Vol-4	
TOWN <u>Catonville</u>		TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>House In The Pine N. H.</u>		STREET ADDRESS (If rural, give location) <u>541 Yale Ave</u>	
3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)
<u>Mary</u>	<u>C.</u>	<u>Wayson</u>	
6. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>2-24-1886</u>
			9. AGE last birthday <u>71</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
<u>Housewife</u>		<u>MD</u>	
13. FATHER'S NAME <u>Michael Euegan</u>	14. MOTHER'S MAIDEN NAME <u>Ida Kuselov</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY No.	17. INFORMANT AND ADDRESS	
<u>No</u>		<u>Mrs. Louis Sweetman - 541 Yale Ave Baltimore</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

141X Immediate cause (a) General Carcinoma

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Carcinoma of Tongue

(c)

INTERVAL BETWEEN ONSET AND DEATH

2 Mos14 Mos

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

20. AUTOPSY?

Yes ☐ No ☐

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 23, 1956, to Feb 24, 1957, that I last saw the deceased alive on 2/22, 1957, and that death occurred at 6:30 P.M. from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Feb 24 1957

Mrs. Joe Senese

J.W.E. Hester - Wash. D.C.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

*James C. [unclear]
[unclear] of [unclear]*

BUREAU V. 3

FEB 28 1957

RECEIVED

[Faint handwritten text, possibly a signature or date]

1596

CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 3 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ALPHONSO Middle W. Last WHITE				4. DATE OF DEATH Month February Day 26 Year 19 57			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 17, 1923	
9. AGE (In years last birthday) yrs. 33		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Warehouseman				10b. KIND OF BUSINESS OR INDUSTRY Wholesale Groc.Co.		11. BIRTHPLACE (State or foreign country) Paces, Virginia	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Luther White				14. MOTHER'S MAIDEN NAME Fannie Mosley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW II				16. SOCIAL SECURITY NO. 230-20-2810			
17. INFORMANT Clin. Records, Vet. Adm. Hospital, Ft. Howard, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) TUBERCULOUS MENINGITIS 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) PULMONARY TUBERCULOSIS DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 10 DAYS 2 YRS. 6 MOS.
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from February 23, 19 57 , to February 26, 19 57 , and that death occurred at 5:15 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Irving Freeman M.D.				ADDRESS (Street, city or town, state) VA HOSPITAL, FT. HOWARD, MARYLAND DATE SIGNED 2/26/57			
PHYSICIAN'S NAME (Type) IRVING FREEMAN, M.D., Chief, Medical Service, Ft. Howard, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/3/1957		22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Marshall Hayes, 638 N. Gilmore St., Balto., Md.				ADDRESS		24a. REC'D BY REGISTRAR DATE 28 1957	
				24b. REGISTRAR'S SIGNATURE <i>Arsonal Fisher</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FEB 28 1957

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1597 CERTIFICATE OF DEATH

01605

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ridgeway Manor Convl.Home		d. STREET ADDRESS 1 755 Westhills Pkwy.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Harry Middle N. Last Wickers		4. DATE OF DEATH Month Feb. Day 3, Year 1957	
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 1, 1876
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Guard, Savings Bank Of Balto.		10b. KIND OF BUSINESS OR INDUSTRY Md.	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Wickers		14. MOTHER'S MAIDEN NAME Elizabeth	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 215-22-5178	
17. INFORMANT Mrs A.L. Jaeger,		Address 755 Westhills Pkwy	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardiovascular Heart disease DUE TO (c) year			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 15, 1956 to Feb 3, 1957 , that I last saw the deceased alive on 2-2, 1957 , and that death occurred at 3:48 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE William L. Fearing		ADDRESS (Street, city or town, state) 3025 Belair Road	
PHYSICIAN'S NAME (Type) WILLIAM L. FEARING		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 6/57	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Harry H. Witzke,		ADDRESS 4101 Edmondson Ave.	
24a. REC'D BY REGISTRAR FEB 6 '57		24b. REGISTRAR'S SIGNATURE W. H. Beach	

CERTIFICATE OF DEATH

1957

THE STATE OF MARYLAND

RECEIVED
FEB 6 1957
BUREAU V. 3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrars prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01606

1598

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3 Vol-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ridgeway Manor Nursing Home		d. STREET ADDRESS 11 S. Woodington Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Gardner Middle Amos Last Wicks, Sr.		4. DATE OF DEATH Feb. 25/57 Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 4, 1867
9. AGE (In years last birthday) 89 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cabinet Maker		10b. KIND OF BUSINESS OR INDUSTRY Glen L. Martin	
11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Gardner Wicks		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 218 09 4388	
17. INFORMANT Miss Margaret S. Wicks		Address 11 S. Woodington Rd	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 443x DUE TO Advanced arteriosclerosis + hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardio-vascular disease, with DUE TO myocardial degenerative. (c)			INTERVAL BETWEEN ONSET AND DEATH 4 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 5 Aug., 1955 to 25 Feb., 1957 , that I last saw the deceased alive on 24 Feb., 1957 , and that death occurred at 1:40 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Emil H Henning Jr		ADDRESS (Street, city or town, state) 601 Winans Way Balto Md	
PHYSICIAN'S NAME (Type) EMIL H HENNING JR		DATE SIGNED 27 Feb 57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/28/57	
22c. NAME OF CEMETERY OR CREMATORY London Park		22d. LOCATION (City, town, or county) (State) Baltimore 29 Md	
23. FUNERAL DIRECTOR'S SIGNATURE Harry H. Witzke, 4101 Edmondson Ave		24a. REC'D BY REGISTRAR AND REGISTRAR'S SIGNATURE Alfred	
DATE MAR 4 '57			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. S.

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NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		45		M		W		JAN 15 1892		BALTIMORE, MD.	
MARRIAGE		DATE		PLACE		NAME OF SPOUSE		DATE OF DEATH		PLACE OF DEATH	
MARRIED		JAN 15 1915		BALTIMORE, MD.		JAMES H. HARRIS		JAN 15 1937		BALTIMORE, MD.	
OCCUPATION		DATE		PLACE		NAME OF EMPLOYER		DATE OF DEATH		PLACE OF DEATH	
LABORER		JAN 15 1937		BALTIMORE, MD.		JAMES H. HARRIS		JAN 15 1937		BALTIMORE, MD.	
CAUSE OF DEATH		DATE		PLACE		NAME OF PHYSICIAN		DATE OF DEATH		PLACE OF DEATH	
HEART DISEASE		JAN 15 1937		BALTIMORE, MD.		JAMES H. HARRIS		JAN 15 1937		BALTIMORE, MD.	
MANNER OF DEATH		DATE		PLACE		NAME OF PHYSICIAN		DATE OF DEATH		PLACE OF DEATH	
NATURAL		JAN 15 1937		BALTIMORE, MD.		JAMES H. HARRIS		JAN 15 1937		BALTIMORE, MD.	
SIGNATURE OF PHYSICIAN		DATE		PLACE		NAME OF PHYSICIAN		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HARRIS		JAN 15 1937		BALTIMORE, MD.		JAMES H. HARRIS		JAN 15 1937		BALTIMORE, MD.	
SIGNATURE OF REGISTRAR		DATE		PLACE		NAME OF REGISTRAR		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HARRIS		JAN 15 1937		BALTIMORE, MD.		JAMES H. HARRIS		JAN 15 1937		BALTIMORE, MD.	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1599

CERTIFICATE OF DEATH

Reg. Dist. No.

016057

1. PLACE OF DEATH o. COUNTY <u>Balto Co</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kingsville md</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kingsville md</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Belair Rd Kingsville md</u>				d. STREET ADDRESS <u>Belair Rd</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Lydia</u> Middle <u>S.</u> Last <u>Williams</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>2</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 12-1880</u>	
9. AGE (In years lost birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>			
11. BIRTHPLACE (State or foreign country) <u>Balto Co md</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Christian Mast</u>				14. MOTHER'S MAIDEN NAME <u>Malinda J Bears</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT Address <u>Mrs Emily Hagy Belair Rd Kingsville md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congestive Heart failure - Compensated</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Nov.</u> , 19 <u>56</u> , to <u>Feb.</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Feb. 2</u> , 19 <u>57</u> , and that death occurred at <u>2:45</u> P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Kingsville Md.</u> DATE SIGNED <u>2-2-57</u> ACTUAL SIGNATURE <u>William A. Tyson</u> M.D. PHYSICIAN'S NAME (Type) <u>William A. Tyson</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/5/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fork Methodist Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Co md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lessahn Funeral Home 7401 Belair Rd</u> ADDRESS <u>FEB 4 1957</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Dr. Walter H. Smith</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with their registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

RECEIVED
FEB 4 1957
BUREAU V. 2

1841/01 2/2/57
10K with 1st 2m

James Thomas Brown 4411 Balto Rd

NO Name Mrs Emily Huggs Balto Rd Kingville Md

Christian Church

Houseswife + Home Balto Co Md R 2C

Female White R 2011-1310

Balto Rd Kingville Md
Kingville Md wife
Balto Co

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1600

CERTIFICATE OF DEATH

01608

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE OWINGS MILLS b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TEXAS- COCKEYSVILLE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OWINGS MILLS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION BALTIMORE COUNTY HOME				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last THOMAS WILLIAMS				4. DATE OF DEATH Month Day Year FEB 16 19 57			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JAN. 22, 19 72	
9. AGE (In years last birthday) 85 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARM LABORER		10b. KIND OF BUSINESS OR INDUSTRY FARM		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME WILLIAM WILLIAMS			
14. MOTHER'S MAIDEN NAME SUSAN WINPENNY				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no			
16. SOCIAL SECURITY NO. none				17. INFORMANT Martha Howard Young - Wynnan Road - Owings Mills			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardio-renal disease 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Right inguinal hernia						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Cockeysville, Md.				20g. (County) Cockeysville, Md.			
20h. (State) Md.				20i. (State) Md.			
21. I certify that I attended the deceased from May 1950 to February 1957 that I last saw the deceased alive on February 11, 1957 , and that death occurred at 3 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Elizabeth B. Sherrill M.D.				ADDRESS (Street, city or town, state) Cockeysville, Md.			
DATE SIGNED 2/16/57				PHYSICIAN'S NAME (Type) Elizabeth B. Sherrill			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF Feb. 19 / 57		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet	
22d. LOCATION (City, town, or county) Old Court Road Butts				22e. (State) Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Edmund A. ...				ADDRESS 4600 Liberty Bldg. Ave		24a. REC'D BY REGISTRAR DATE Feb. 16 / 57	
24b. REGISTRAR'S SIGNATURE Wm. J. Chilcoat							

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
MAYNARD		M		45		1912		BALTIMORE		MD		USA			
OCCUPATION		MARITAL STATUS		EDUCATION		RELIGION		RACE		COLOR		HEIGHT		WEIGHT	
LABORER		MARRIED		HIGH SCHOOL		METHODIST		WHITE		WHITE		5' 8"		160	
CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY	
HEART DISEASE		NATURAL		2 WEEKS		1957		BALTIMORE		MD		USA			
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF CLERK		SIGNATURE OF REGISTRAR		SIGNATURE OF JUDGE		SIGNATURE OF SHERIFF	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
DATE		TIME		PLACE		CITY		STATE		COUNTRY		COUNTY		TOWNSHIP	
1957		10:00 AM		BALTIMORE		MD		USA				BALTIMORE		BALTIMORE	

BUREAU V. S.

EB 19 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01609

1601

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo. ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 3yr8mthldy	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Joseph Middle H. Last Wilson, Sr.		4. DATE OF DEATH February 12 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 30, 1876
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector		10b. KIND OF BUSINESS OR INDUSTRY unknown	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) UNKNOWN		16. SOCIAL SECURITY NO. UNKNOWN	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral thrombosis 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Duodenal ulcers with hemorrhage			
INTERVAL BETWEEN ONSET AND DEATH 3 weeks years			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 27 , 19 57 , to Feb. 12 , 19 57 , that I last saw the deceased alive on Feb. 12 , 19 57 , and that death occurred at 4:50 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 2-12-57			
ACTUAL SIGNATURE Louie Frances Woodward		M.D. SPRING GROVE STATE HOSPITAL	
PHYSICIAN'S NAME (Type) Louie Frances Woodward		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/15/57	
22c. NAME OF CEMETERY OR CREMATORY Madison Chapel		22d. LOCATION (City, town, or county) (State) Seat Pleasant Md	
23. FUNERAL DIRECTOR'S SIGNATURE W W Chambers		ADDRESS Co - 11400 Chapin St Wash D.C.	
24a. REC'D BY REGISTRAR FEB 14 '57		24b. REGISTRAR'S SIGNATURE W. D. Beach	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

NAME OF DECEASED		DATE OF DEATH		PLACE OF DEATH	
SEX		AGE		OCCUPATION	
MARRIAGE		EDUCATION		RELIGION	
BIRTH		DEATH		CAUSE OF DEATH	
MANNER OF DEATH		PERIOD OF ILLNESS		MEDICAL ATTENDANCE	
PREVIOUS ILLNESS		TREATMENT		POST-MORTEM	
FAMILY HISTORY		SOCIAL HISTORY		HISTORICAL DATA	
PHYSICAL EXAMINATION		LABORATORY EXAMINATIONS		PATHOLOGICAL FINDINGS	
CLINICAL COURSE		TREATMENT		OUTCOME	
FAMILY HISTORY		SOCIAL HISTORY		HISTORICAL DATA	
PHYSICAL EXAMINATION		LABORATORY EXAMINATIONS		PATHOLOGICAL FINDINGS	
CLINICAL COURSE		TREATMENT		OUTCOME	

BUREAU V. S.

FEB 14 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
1602
CERTIFICATE OF DEATH

01610

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stevenson</u>		c. LENGTH OF STAY IN 1b <u>26 Yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Stevenson Rd. Extended</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Marion Clare Wilson</u>		4. DATE OF DEATH Month Day Year <u>Feb. 27 19 57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 23, 1894</u>
9. AGE (In years last birthday) <u>62</u> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William E. Jones</u>		14. MOTHER'S MAIDEN NAME <u>Mary L. Hood</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Charles A. Wilson Jr. Stevenson, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the Pancreas</u> 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>14 1/2 months</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>November 19, 56</u> , to <u>February 27, 1957</u> , that I last saw the deceased alive on <u>February 27, 1957</u> , and that death occurred at <u>5:30 p. m.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Warde B. Coover M.D. 6 E. Eager St. Balt-2 - 2/28/57</u>			
ACTUAL SIGNATURE <u>WARDE B. COOVER</u> PHYSICIAN'S NAME (Type) <u>WARDE B. FALLAX</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-1-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>		22d. LOCATION (City, town, or county) (State) <u>Pikesville, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell</u>		24. REC'D BY REGISTRAR <u>1957</u>	
ADDRESS <u>Pikesville, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Dorothy Newell</u>	

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITALS

RECEIVED
BUREAU V. S.
 MAR 1 1957

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES J. JONES		45		M		W		JAN 1 1912		NEW YORK	
MARRIAGE		DATE		PLACE		NAME OF SPOUSE		DATE OF DEATH		PLACE OF DEATH	
MARRIED		JAN 1 1935		NEW YORK		JANE J. JONES		JAN 1 1957		NEW YORK	
OCCUPATION		DATE		PLACE		NAME OF EMPLOYER		DATE OF DEATH		PLACE OF DEATH	
CLERK		JAN 1 1957		NEW YORK		ABC COMPANY		JAN 1 1957		NEW YORK	
CAUSE OF DEATH		DATE		PLACE		NAME OF PHYSICIAN		DATE OF DEATH		PLACE OF DEATH	
HEART DISEASE		JAN 1 1957		NEW YORK		DR. J. J. JONES		JAN 1 1957		NEW YORK	
MANNER OF DEATH		DATE		PLACE		NAME OF CORONER		DATE OF DEATH		PLACE OF DEATH	
NATURAL		JAN 1 1957		NEW YORK		JOHN J. JONES		JAN 1 1957		NEW YORK	
SIGNATURE OF DECEASED		DATE		PLACE		NAME OF WITNESS		DATE OF DEATH		PLACE OF DEATH	
JAMES J. JONES		JAN 1 1957		NEW YORK		JOHN J. JONES		JAN 1 1957		NEW YORK	
SIGNATURE OF SPOUSE		DATE		PLACE		NAME OF WITNESS		DATE OF DEATH		PLACE OF DEATH	
JANE J. JONES		JAN 1 1957		NEW YORK		JOHN J. JONES		JAN 1 1957		NEW YORK	
SIGNATURE OF PHYSICIAN		DATE		PLACE		NAME OF WITNESS		DATE OF DEATH		PLACE OF DEATH	
DR. J. J. JONES		JAN 1 1957		NEW YORK		JOHN J. JONES		JAN 1 1957		NEW YORK	
SIGNATURE OF CORONER		DATE		PLACE		NAME OF WITNESS		DATE OF DEATH		PLACE OF DEATH	
JOHN J. JONES		JAN 1 1957		NEW YORK		JOHN J. JONES		JAN 1 1957		NEW YORK	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1603

CERTIFICATE OF DEATH

Reg. Dist. No.

01611

43

1. NAME OF DECEASED (Type or Print) <i>Penelope Wilson</i>		2. DATE OF DEATH <i>3-6-57</i>	
3. PLACE OF DEATH A. Baltimore City, Maryland B. FULL NAME OF HOSPITAL OR INSTITUTION <i>Home</i>		4. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN <i>Baltimore County-Rural</i> D. STREET ADDRESS (If rural, give location) <i>9601 Belair Road</i>	
5. SEX <i>F.</i>	6. COLOR OR RACE <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>widowed</i>	8. DATE OF BIRTH <i>June-16-1881</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <i>75</i>
13. FATHER'S NAME <i>Morgan P. Wilson</i>		11. BIRTHPLACE (State or foreign country) <i>Henry Co Va</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <i>no</i>		12. CITIZEN OF WHAT COUNTRY?	
16. SOCIAL SECURITY NO. <i>no</i>		17. INFORMANT ADDRESS <i>Mary Dudley - 9601 Belair Road</i>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Coronary thrombosis</i> DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>Arteriosclerotic heart disease</i> DUE TO OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19. DATE OF OPERATION <i>28 December 1956</i>			
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <i>28 December 1956</i> to <i>6 February 1957</i> , that (I) (we) last saw the deceased alive on <i>6 February 1957</i> , and that death occurred at <i>10:30 P.m.</i> from the causes and on the date stated above.	
23A. SIGNATURE <i>George D. Edwards</i> M.D.		23B. ADDRESS	
23C. DATE SIGNED		24A. REMOVAL (Specify) <i>Removal</i>	
24B. DATE <i>2-7-57</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Trinity Funeral Home</i>	
24D. LOCATION (City, town, or county) (State) <i>Lexville M.C.</i>		25. FUNERAL DIRECTOR <i>Carl S. Robinson Funeral Home</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>2/11/57</i>		REGISTERED SIGNATURE <i>W. H. Hedrick</i>	

THIS IS A PERMANENT RECORD.

PLEASE TYPE, OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN.

Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. This certificate must be filed with the Bureau of Vital Records within three (3) days after the death.

BUREAU V. S.

FEB 14 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
3 should be detached for use as the burial-transit permit. Then please remove carbon papers. 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01612

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 5 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EDWARD Middle (NMI) Last WINDSOR		4. DATE OF DEATH Month February Day 16 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/27/10
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Orderly		9b. KIND OF BUSINESS OR INDUSTRY Hospital	
10a. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Windsor		14. MOTHER'S MAIDEN NAME Lucy MN: Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWII		16. SOCIAL SECURITY NO. 220-12-0029	
17. INFORMANT Clin. Rec. Vets. Admin. Hospital, Ft. Howard, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ULCER, GASTRIC, PERFORATED 540.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PERITONITIS DUE TO (c) PNEUMONIA		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN 4 DAYS 4 DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 11, 19 57, to February 16, 19 57 , and that death occurred at 7:15 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Veterans Administration Hospital 2/17/57 ACTUAL SIGNATURE Roland D. Ponce de Leon M.D. PHYSICIAN'S NAME (Type) ROLAND D. PONCE DE LEON, M.D. Fort Howard, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-18-57	
22c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park		22d. LOCATION (City, town, or county) (State) Cambridge, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook - Blight, Inc ADDRESS Wm Cook - Blight Funeral Home 6009 Harford Rd. Balto, Md.		24a. REC'D BY REGISTRAR 2-18-57	
24b. REGISTRAR'S SIGNATURE Dawson L. Farley			

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BIRTH ONE 18

BUREAU V. S.

FEB 19 1957

RECEIVED

1441

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROSEMONT</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROSEMONT</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>GEORGE WIRSCHING</u> First Middle Last		4. DATE OF DEATH <u>FEB 12</u> Month Day Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>WH</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 6 1887</u> 9. AGE (In years last birthday) <u>69</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CHIEF, SCHILLHASE RESTAURANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GERMAN</u>	
11. BIRTHPLACE (State or foreign country) <u>GERMAN</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>VALENTINE WIRSCHING</u>		14. MOTHER'S MAIDEN NAME <u>KUNIGUNDIE WIRSCHING</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>E</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-05-6135</u> 17. INFORMANT <u>MRS M. WIRSCHING</u> Address <u>3014 MD AVE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma, right lung</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>3 mo (?)</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4221 Arteriosclerotic Cardio-vascular disease</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov</u> , 1956, to <u>Feb 12</u> , 1957, that I last saw the deceased alive on <u>Feb 10</u> , 1957, and that death occurred at <u>10 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Delmar Laughlin</u>		ADDRESS (Street, city or town, state) <u>4508 Edmondson Village</u> DATE SIGNED <u>2/13/57</u>	
PHYSICIAN'S NAME (Type) <u>D.C. MacLaughlin</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>2/16/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>LOUWON PK</u>	22d. LOCATION (City, town, or county) (State) <u>TREVERICK AVE</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>GEORGE IMBACH</u> ADDRESS <u>525 N. LYND HURST ST</u>		24a. REC'D BY REGISTRAR <u>W. H. H. H.</u> 24b. REGISTRAR'S SIGNATURE <u>W. H. H. H.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1957

01013

BUREAU V. S.

FEB 14 1957

RECEIVED

Form with multiple sections for death certificate, including fields for name, date, and location. The form is partially filled out with handwritten text.

Vertical text on the right margin, possibly a filing or processing stamp.

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01614

1605

CERTIFICATE OF DEATH

Reg. Dist. No.

37

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Wilson</u>				c. LENGTH OF STAY IN 1b <u>3 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mt. Wilson State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>VERONICA</u> Middle <u>FRANCES</u> Last <u>WISNIEWSKI</u>				4. DATE OF DEATH Month <u>FEBR.</u> Day <u>27</u> Year <u>1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-7-18</u>	
9. AGE (In years last birthday) <u>38</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>GROCERY STORE</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>FRANCIS WISNIEWSKI</u>				14. MOTHER'S MAIDEN NAME <u>VERONICA ZAK</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>213-10-6335</u>		17. INFORMANT Address <u>Hospital records, Mt. Wilson State Hospital</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY TUBERCULOSIS, FAR ADVANCED</u> DUE TO <u>3 years & 3 months</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>12-2-</u> , 19 <u>53</u> , to <u>2-27-</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2-27-</u> , 19 <u>57</u> , and that death occurred at <u>9⁴⁰</u> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u> </u> DATE SIGNED <u> </u>							
ACTUAL SIGNATURE <u>William Newcomer</u> M.D.							
PHYSICIAN'S NAME (Type) <u>William Newcomer, M.D. Supt.</u>				Mt. Wilson, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-1-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST. STANISLAUS</u>		22d. LOCATION (City, town, or county) (State) <u>DUNDALK AVE</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mare Fialkowski</u>				ADDRESS <u>10005 KENWOOD AVE</u>		24a. REC'D BY REGISTRAR DATE <u>2/28/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Dorothy Jewell</u>			

BUREAU V. 8

MAP 1
1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01615

1606

CERTIFICATE OF DEATH

Reg. Dist. No.

35

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Hall</u>		c. LENGTH OF STAY IN 1b <u>20 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wiseburg Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Blanche</u> Middle <u>L.</u> Last <u>Wood</u>		4. DATE OF DEATH Month <u>February</u> Day <u>17</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 7, 1900</u>
9. AGE (In years last birthday) <u>56</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Stewartstown, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Charles Gemmi II</u>		14. MOTHER'S MAIDEN NAME <u>Susan Orwig</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Wm. W. Wood, White Hall Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma General Abdominal</u> <u>199.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. 19 <u>57</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1956</u> to <u>Feb 19 1957</u> , that I last saw the deceased alive on <u>Feb 17 1957</u> , and that death occurred at <u>7:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Miller Bortner</u>		ADDRESS (Street, city or town, state) <u>White Hall Md.</u>	
DATE SIGNED			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Febr. 20, 1957</u>	<u>Wiseburg Cemetery</u>	<u>White Hall Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	
<u>L. Jacob Kortenstein, New Freedom Pa.</u>		<u>3/20/57</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE	
		<u>Charles L. Fulton</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Reg. No. 100-1000000

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

PREVIOUS ILLNESS

DATE OF PREVIOUS ILLNESS

DATE OF PREVIOUS DEATH

DATE OF PREVIOUS BIRTH

DATE OF PREVIOUS DEATH

DATE OF PREVIOUS BIRTH

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BUREAU V. 3

FEB 25 1957

RECEIVED

1697

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 2yr7mthl4dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edwin Middle O. Last Wood		4. DATE OF DEATH February 16 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 10, 1889
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) plate printer		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George T. Wood		14. MOTHER'S MAIDEN NAME Margaret E. Wood	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown --		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) due to Generalized arteriosclerosis DUE TO (c) --		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 7, 1957 to Feb. 16, 1957 , that I last saw the deceased alive on Feb. 16, 1957 , and that death occurred at 1145 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachslar M.D.		DATE SIGNED	
PHYSICIAN'S NAME (Type) STELLA WACHSLAR		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-20-57	22c. NAME OF CEMETERY OR CREMATORY mt Olivet Cemetery	22d. LOCATION (City, town, or county) (State) Washington, D.C.
23. FUNERAL DIRECTOR'S SIGNATURE Francis J. Collins		24a. REC'D BY REGISTRAR 382-14th N.W. Wash. D.C.	24b. REGISTRAR'S SIGNATURE Feb 19 57

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1858

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

01617

282

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 1yr6mt26days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mattie Middle Enss Last Wood				4. DATE OF DEATH Month February Day 3 Year 19 57			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 25 ??		9. AGE (In years last birthday) 62 1/2 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Kansas		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Arthur Enss				14. MOTHER'S MAIDEN NAME Elizabeth			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Vascular Disease DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 936.7 fracture right hip femur							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) was pushed down by another patient, sustaining fracture of right femur					
20c. TIME OF INJURY Month, Day, Year 7:20 AM 11-2-56		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital		20f. (City or town) (County) (State) Catonsville 28, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE George M. Kieffer, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) George M. Kieffer, M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/5/57		22c. NAME OF CEMETERY OR CREMATORY Mt. Zion		22d. LOCATION (City, town, or county) (State) Laura Grove, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Md.				24a. REC'D BY REGISTRAR DATE 2/4/57		24b. REGISTRAR'S SIGNATURE Glenn D. Hauser	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the funeral director prior to burial, cremation, or removal.

FEB 5 1957

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01618

Baltimore County
1435

CERTIFICATE OF DEATH

Reg. Dist. No.

41

1. PLACE OF DEATH o. COUNTY 7001 Dunhill Road MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Balto			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 53Dundalk Hereford Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 7001 Dunhill Road.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) IDA First M Middle WORTMAN Last				4. DATE OF DEATH Feb. 22 Month 19 Year 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 30. 1875		9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months 10 Days 4 Hours 13 Min.	IF UNDER 24 HRS. Hours 13 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Balto Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Louis Thompson				14. MOTHER'S MAIDEN NAME Amanda Foster			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Oscar Wortman Address 7001 Dunhill Road. Dundalk Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio-Sclerotic Cardio-Vasc. Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH 10 yrs.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JAN. 24 , 19 57 , to Feb. 22 , 19 57 , that I last saw the deceased alive on Feb. 20 , 19 57 , and that death occurred at 10:30 P. M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE M.B. Davis				ADDRESS (Street, city or town, state) 6800 MCKINSTRY AVE - Dundalk - Md. 21222			
DATE SIGNED M.B. DAVIS M.D.				DATE SIGNED Feb 25 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 25 57		22c. NAME OF CEMETERY OR CREMATORY Baltimore Md.		22d. LOCATION (City, town, or county) (State) Baltimore City. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook Inc. 1217 St. Paul Street Balto 2 Md.				24a. REC'D BY REGISTRAR Feb 25 1957		24b. REGISTRAR'S SIGNATURE Wm. Kelly	

CERTIFICATE OF DEATH

1957

NAME OF DECEASED Louis Thompson		SEX Male	
DATE OF BIRTH Dec. 30, 1878		PLACE OF BIRTH Baltimore, Md.	
OCCUPATION Laborer		CAUSE OF DEATH Heart Disease	
PLACE OF DEATH Baltimore, Md.		DATE OF DEATH Feb. 25, 1957	
NAME OF PHYSICIAN Dr. J. H. Smith		NAME OF HOSPITAL St. Joseph's Hospital	
NAME OF FUNERAL HOME J. H. Smith & Son		NAME OF BURIAL PLACE St. Joseph's Cemetery	
NAME OF NEXT OF KIN Mrs. J. H. Smith		NAME OF WITNESS Dr. J. H. Smith	
NAME OF REGISTRAR J. H. Smith		NAME OF CLERK J. H. Smith	

RECEIVED
 FEB 25 1957
 BUREAU V. 3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1699

CERTIFICATE OF DEATH

01619

Reg. Dist. No. 33

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown		c. LENGTH OF STAY IN 1b 4 Years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Bond Ave.	
d. STREET ADDRESS / Bond Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Catherine First Middle Last Yox		4. DATE OF DEATH Feb. 23, 1957 Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 30, 1873
9. AGE (In years lost birthday) 85 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Housework	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Conrad Yox		14. MOTHER'S MAIDEN NAME Christine	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Herbert Yox, Reisterstown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL EMBOLUS DUE TO 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROTIC C.V. DISEASE WITH DUE TO (c) AURICULAR FIBRILLATION		INTERVAL BETWEEN ONSET AND DEATH 1 HOUR YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JULY , 1948, to FEBRUARY 23, 1957 , that I last saw the deceased alive on FEB. 23 , 1957, and that death occurred at 11:00 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Martin E. Strobel		ADDRESS (Street, city or town, state) 48 Main St. Reisterstown, Md.	
PHYSICIAN'S NAME (Type) Martin E. Strobel		DATE SIGNED 2/25/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 27, 1957	
22c. NAME OF CEMETERY OR CREMATORY Druid Ridge		22d. LOCATION (City, town, or county) (State) Pikesville Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J.F. Eline & Sons Reisterstown, Md.		24a. REC'D BY REGISTRAR 2-25-57	
ADDRESS J.F. Eline & Sons Reisterstown, Md.		24b. REGISTRAR'S SIGNATURE Mary B. Eline	

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01620

1610 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u> TOWN <u>Cockeysville</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Warren Rd</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u> TOWN <u>Cockeysville</u> STREET ADDRESS (If rural give location) <u>Warren Rd</u>			
3. NAME OF DECEASED (Type or Print) <u>Benjamin Clark</u> (First) (Middle) (Last) <u>Zink Sr</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>February 15</u> 19 <u>57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>17 March 1886</u>	9. AGE last birthday <u>70</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Blacksmith</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Same</u>		11. BIRTHPLACE (State or foreign country) <u>Cockeysville Balt Co. Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Zink</u>				14. MOTHER'S MAIDEN NAME <u>Ellen (Nellie) Clark</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-03-2976</u>		17. INFORMANT & ADDRESS <u>Mildred Mangovan - Same</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 422.1 IMMEDIATE CAUSE (A) <u>Arterio-sclerotic cardio-vascular disease</u> ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Chronic Bronchitis & Emphysema</u> (C)						10 yrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						over 10 yrs	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1946</u> , to <u>Feb 14</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Feb 14</u> , 19 <u>57</u> , and that death occurred at <u>7:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Robert T. Kees</u> M.D.				ADDRESS (Street, city, town, state) <u>Cockeysville Md</u> DATE SIGNED <u>15 February 1957</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2-18-57</u>		NAME OF CEMETERY OR CREMATORY <u>Sherwood</u>		LOCATION (City, town, or county) (State) <u>Cockeysville, Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Al. Leach</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell - Baltimore</u>		ADDRESS <u>2nd</u>	
DATE <u>FEB 19 57</u>							

1088

1910 CERTIFICATE OF DEATH

Page One of Two

1. Name of deceased (Print or write full name)

2. Sex (Male or Female)
3. Age (Years and Months)
4. Date of birth (Month, Day, Year)
5. Place of birth (City, State, Country)

6. Marital status (Single, Married, Widowed, Divorced)

7. Occupation (Print or write)

8. Cause of death (Print or write)

9. Medical history (Print or write)
10. Name of attending physician (Print or write)
11. Name of hospital or institution (Print or write)
12. Date of death (Month, Day, Year)
13. Time of death (Hour, Minute)
14. Place of death (City, State, Country)
15. Name of informant (Print or write)
16. Signature of informant (Print or write)

BUREAU V. S.

FEB 19 1957

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1611 CERTIFICATE OF DEATH

Reg. Dist. No.

01621

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3Y01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 1718 Holbrook Street	
3. NAME OF DECEASED (Type or print) First Solomon Middle Zinser Last Zinser		4. DATE OF DEATH Month February Day 4 Year 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 27, 1889
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) plumber		10b. KIND OF BUSINESS OR INDUSTRY Maryland	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Adolph Zinser		14. MOTHER'S MAIDEN NAME Clementin Zinser	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. 220-09-4526	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Feb. 3 , 19 57 , to Feb. 4 , 19 57 that I last saw the deceased alive on Feb. 4 , 19 57 , and that death occurred at 3:50p. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Gertrude J. Fleischmann		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL	
PHYSICIAN'S NAME (Type) Gertrude Fleischmann, M. D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/7/57	22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cem.	22d. LOCATION (City, town, or county) (State) Woodlawn, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tichener & Sons - Balt.		24a. REC'D BY REGISTRAR Feb 5 57	
ADDRESS Baltimore, Md.		24b. REGISTRAR'S SIGNATURE W. J. Tichener	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1612

CERTIFICATE OF DEATH

016228

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rodgers Forge</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rodgers Forge</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>427 Hopkins Rd.</u>				d. STREET ADDRESS <u>427 Hopkins Rd.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Howard</u> Middle <u>L.</u> Last <u>Zupnik</u>				4. DATE OF DEATH Month <u>February</u> Day <u>15</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 26 1905</u>	
9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Doctor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Medicine Surgery</u>			
11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Louis Zupnik</u>				14. MOTHER'S MAIDEN NAME <u>Annie Rudolph</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <u></u>			
17. INFORMANT <u>Mrs Katherine Zupnik, 427 Hopkins Rd, Balto. 12 Md.</u>				Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Cerebral Paralysis</u> <u>180X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Thrombosis</u> DUE TO (c) <u>Hypertension of Kidney</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Oct 1</u> , 19 <u>57</u> , to <u>Feb 15</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2-15-</u> , 19 <u>57</u> , and that death occurred at <u>8 P. M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>715 N. Charles St. Baltimore, Md.</u> DATE SIGNED <u>2-15-57</u>							
ACTUAL SIGNATURE <u>J. Demarco Jr.</u> M.D.				DATE SIGNED <u>2-15-57</u>			
PHYSICIAN'S NAME (Type) <u>J. Demarco Jr.</u>				DATE SIGNED <u>2-15-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Febr. 19 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Freedom Cem. New Freedom, Penna.</u>		22d. LOCATION (City, town, or county) (State) <u>New Freedom, Penna.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Isaac Harkness</u> ADDRESS <u>New Freedom, Pa.</u>				24a. REC'D BY REGISTRAR <u>DATE FEB 19 1957</u>			
				24b. REGISTRAR'S SIGNATURE <u>Mabel Grange</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

THIS

FEB 19 1957

BUREAU V. S.

RECEIVED